NW Creative Counseling
2027 SE Jefferson Street Suite 205 C
Milwaukie, OR 97222

PRIVACY, CONSENT, & OFFICE POLICIES

WHAT TO EXPECT

To provide the best possible care, it's important for me to learn about your reasons for seeking therapy, your past experiences with therapy, your past and current relationships, and your future goals. Being open and honest will help create a therapeutic partnership between us, helping me understand the specific needs of your situations and specific goals to be focused on. I will always welcome your continued feedback, questions or concerns throughout this process. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one friend or family member is viewed quite negatively by another. Change will sometimes be easy and swift, but more often it will be slower.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Nicole L Craig to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. Should there be a subpoena from a judge requiring court appearance, the fee is $1500.

POTENTIAL RISKS

While therapy can help facilitate important life changes, the process itself may present you or those with whom you are close with new challenges. Some individuals experience discomfort or other difficult emotions during therapy, especially during the early stages. These are common experiences and may be important in your developing new abilities to manage difficulty in other areas of your life. As you make changes it may challenge others in your life who are not involved in your process of change. I always encourage you to bring these challenges to session should they occur. There is no guarantee that psychotherapy will yield positive or intended results.

PRIVACY ISSUES

What you choose to discuss with me is private and I will not share anything we talk about with others unless I have your written permission to do so. Similarly, I will not seek out or accept information from others who know you without receiving your permission. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. Under the provisions of the Health Care Information Act of 1992, I will always act so as to protect your privacy even if you do release me in writing to share information about you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Exceptions to these protections are as follows:

* In cases in which you disclose or imply a plan to harm yourself, I will notify people who can help you protect yourself, such as family, health care providers, or the police.

* If you disclose intentions to harm another person, I will make a report to authorities and reserve the right to tell the person in danger; if you suggest that you have abused or are abusing a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, I will report this information to authorities.

* If you were to bring suit against me, I may need to break confidentiality in a legal defense.

* If I am subpoenaed or court ordered to testify in court, I may have to give information about you without your permission. If I am subpoenaed or receive a court order, I will make an effort to contact you. If you oppose release of information, a court may nevertheless order me to disclose information about you.

These exceptions rarely occur, but it is important for you to be aware of them. I encourage you to talk to me about any concerns related to privacy at any time in our work.

APPOINTMENTS AND COMMUNICATION

Sessions are by appointment and are 60-minutes in length. Please call or e-mail within at least 24 hours of your scheduled appointment if you need to cancel or reschedule. You will be responsible for a $50 fee for appointments missed without 24 hours' notice, which is *not billable to insurance.* There is never a charge for missed appointments due to inclement weather or illness. I frequently work with individuals who are medically fragile, so if you are coming down with an illness or are currently symptomatic *please* do not come to the office. If you are 15 minutes or more late without communication the appointment is considered missed and I may leave the office. If late cancellations or no-shows are a pattern (three or more) I will be unable to keep a regularly scheduled time for you and may offer either alternative scheduling options or referrals to another provider, depending on the situation. Though it is easy to reopen a case, they are considered closed if we do not have an appointment for 60 days.

I do not provide emergency services due to schedule limitations and time off. Should you find that you are in an emergency mental health situation or feel you may harm yourself please call the **Clackamas County Crisis Line at (503) 655-8585, the Multnomah County Crisis Line (503-988-4888), or 911.** You can also access **Cascadia's Behavioral Health Urgent Walk-in Clinic, Unity Center for Behavioral Health,** or nearest **emergency room** of your choice. Please leave me a voicemail as well if able so that I may follow up with you.

I do take occasional time away, and may not be able to respond to messages (via email or phone). I will always provide you with advanced notice and can provide the contact information of a colleague who may provide support while I'm away. You can leave me voicemail or email me anytime. I will do my best to respond within 24-48 hours on weekdays, but do take longer when I am out of the office for time off.

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It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Please do not use email or faxes for emergencies or to provide detailed clinical information.

FEES AND PAYMENT

My standard fee is $150 per 60-minute session for individual sessions, due at the beginning of each visit payable by cash, check, or credit card. I do currently bill some insurance companies which I am contracted with, and can provide paperwork for billing out of network for others. Copays are due at time of service. If there are any changes to your insurance during our time working together, you will be responsible for tracking these (new deductibles, new coverage, ect) and for any amount not covered. If desired, I will provide a receipt upon request. Please inquire about sliding scale options (limited availability), or speak to me if you are having financial difficulties during treatment.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Nicole Craig has no control or knowledge over what insurance companies do with the information he/she submits or who has access to this information. You must be notified that submitting a mental health invoice for reimbursement potentially carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

CONSENT FOR THERAPY

I have read this document and have had the opportunity to ask questions about it. I understand my rights to privacy and that there are risks associated with therapy. I understand that I may refuse services at any time. I agree to abide by the payment policy outlined above and accept full responsibility for any and all fees incurred for my therapy. I understand that the therapist has not issued and will not issue any guarantee of treatment effects or number of sessions necessary. This agreement is entered into voluntarily by the client with competency, understanding, and knowledge of potential consequences.

Please sign and date this form and bring it to your first session:

Signature _____Date_____

Name (Print)_____

Parent (if under 18) _____Date_____

Name (Print)_____Relationship_____