Mindy LaFramboise, MA, LPC
Licensed Professional Counselor
www.MindyLaframboise.com

Consent to Treatment & Rights and Responsibilities

Welcome. I look forward to providing you high quality, Solution-Oriented services. I am committed to providing a barrier-free environment for all people. In professional treatment relationships, there are Rights and Responsibilities of both the provider and the client. Some of these Rights and Responsibilities are briefly reviewed here. Please ask questions and express concerns.

Where this document refers to "you", it means both the client and/or the client's legal guardian.

Risks and Benefits

Mental health treatment has both risks and benefits. I work to reduce the risks to you by working closely with you. I encourage you to ask me about the potential risks to you from treatment. I believe getting help most often outweighs the risks and lessens the risks of not getting treatment.

You have the right to discontinue treatment at any time. I encourage you to discuss this choice openly with me. Likewise, I may need to terminate your treatment if, in my judgment, you are not benefiting.

Solution-Oriented, strengths-based treatment is generally effective in helping people solve problems for which they are seeking solutions. Often, clients report a significant decrease in feelings of distress, improved relationships, and increased problem-solving abilities. Most people benefit from my services.

Emergencies and Urgent Need

Outside of regular business hours, or if you are experiencing a mental health emergency, you may call the Multnomah County Crisis Line at 503-988-4888.

During business hours, please call me. Please note that due to the volume of calls I receive it may take me 24-48 hours to return calls. If you require more immediate assistance, please leave one message indicating you have an urgent need, the nature of the need, and **one** phone number to reach you.

Your Privacy and Limits to your Privacy

A description of how your medical information may be used and disclosed can be reviewed in the Notice of Privacy Practices (NPP). You may request a copy of the NPP any time.

Your treatment is confidential. Information about your mental health status, provision of care, or payment for care is considered Protected Health Information (PHI). Federal and State laws provide legal protections for this information as outlined in the NPP. This means that what you tell me is private. Generally, I will not share anything about you with anyone unless I have your written authorization.

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To protect your privacy, I will not use email to talk with you about your needs or your care.

Written information about you is kept in a confidential clinical chart. Your chart is secured when not in use. You may request to view your chart by setting an appointment to review your chart. I will explain the chart and answer questions.

Generally, before I give your information to someone, you must first complete an Authorization to Release Confidential Information (ROI). You may revoke the authorization in writing. You may revoke the authorization at any time provided that I have not taken any action in reliance on the authorization.

Exceptions to Privacy and Confidentiality

There are times when I may share your Protected Health Information without your consent. These include:

Colleagues, supervision, and consultants. I may talk about you with colleagues and/or consultants or in a supervision consultation group to get advice about your treatment or coordinate your care. This is a professional consultation and your identifying information will be protected.

Emergency Situations. I may share information about you with other professionals or agencies in a medical or mental health emergency or when following up after the emergency.

Future Harm. If I learn that you or someone else might be seriously harmed in the future (including by suicide), I may have to share protected health information with the appropriate authority.

Child Abuse, Elder Abuse, Abuse of a Mentally Ill Adult or Abuse of an Adult with Developmental disabilities. I am mandated by law to report suspected abuse. This includes harm to a child, elderly person, or someone who is mentally ill. Under The Oregon Mandatory Reporting Law, child abuse includes physical abuse, neglect, mental injury or emotional maltreatment, sexual abuse, or sexual exploitation and threat of harm to a child, which may include exposure to domestic violence. By law I have the right to release confidential information in order to cooperate with an investigation of potential abuse. I will comply with these laws and my ethical obligations to assure the safety of these people.

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Crimes against me. I will tell the police and courts about any crime by a client committed at my location, or against me, or about any threat to do such a crime.

Subpoena or Court Order. If I am ordered to go to court, I may have to give information from your chart without your permission. I will release information as ordered by the court or subject to a subpoena that conforms to state and federal law.

Access to Records by Non-Custodial Parents. If your child is in treatment, both parents have rights to see and copy your child's chart. Also, both parents can talk to me. Only the court can limit this right of non-custodial parents.

Request to Amend Your Records

You have the right to request that I amend the health information contained in your clinical record. I may deny your request under limited circumstances, including those circumstances in which the information you wish to amend is accurate and complete.

Coordinating Care

I want to emphasize the importance of coordinating care with those people involved in your health care. It is my general practice to request you sign a Release of Confidential Information authorizing me to communicate with your Primary Care Physician (PCP) about your treatment. However, I will not communicate with your PCP without your consent.

In order to coordinate your care, I may ask you to provide me with a Release of Confidential Information authorizing me to share your information with others involved in your care. You may refuse this request; however, in limited circumstances, I may be unable to continue providing services for you.

Insurance and Managed Care

If you are requesting that your health insurance pay for the treatment you receive here, they are likely to request information about your problems and the treatment provided, as well as itemized statements of charges. By signing this Consent to Treatment Form and authorizing me to bill your insurance, you are giving me permission to release information to the insurance company about your treatment. I may use electronic means to bill your insurance. You have the right to review any information I send to your insurance company.

Fees and Payment

There are charges for all services including counseling, consultation, preparation of special reports or treatment summaries, or other services you may request. If the service is not covered by your insurance or funder, you will be expected to pay for the service. The amount that you will need to pay will be discussed with you in advance.

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You must inform me immediately of any change in your insurance plan. If your insurance changes and you are no longer covered, you are responsible for your bill.

Cancellation Policy and Non-Payment Policy

If you are unable to keep an appointment, you should cancel by phone at least 24 hours in advance or by Monday morning at 8am for Monday appointments. If you fail to cancel in advance, you may be charged a no-show fee. Payment for missed appointments is due at the time of your next visit. If you do not pay your fee plus any balance due at the time of your visit, I may refuse services. Your account may be turned over to a collection agency if you do not pay your fees.

If you fail to show or cancel your appointment on 3 separate occasions, I will close your case.

Similarly, if I have not had contact with you for 3 months, I will close your case. If you wish to re-enter services, you will need to complete all initial paperwork, unless we have discussed this absence.

Effective Date

This notice is effective October 1, 2013.

This packet is yours to keep for your records. Please sign the attached form.

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Statement of Informed Consent to Treatment

I have read, or have had read to me, all of the information above and **I fully understand this information.**

My signature below means that I was given a copy of this handout, "**Consent to Treatment and Rights & Responsibilities**".

I now want to freely give my informed consent for myself, and/or minor child or legal dependant, to be in treatment with Mindy LaFramboise, MA, LPC.

Name of Client:

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Legal Guardian Name*	Signature	Date

_____
Relationship to Client*

This page to remain with therapist records.