Thomas Deshler Ph.D. P.C.
Willamette Valley Family Center, LLC
610 Jefferson Street - Oregon City, Oregon 97045
(503) 657-7235

INFORMED CONSENT AND OFFICE POLICIES

Welcome to Willamette Valley Family Center Thereafter WVFC. This form contains information about fees, insurance billing practices, psychotherapy treatment, confidentiality and WVFC's HIPAA compliance. Should you have additional questions after reading this policy statement, do not hesitate to ask me for clarification. We will give you a copy of these policies. Please keep them for your records.

CONSENT TO TREATMENT

The practitioners of Willamette Valley Family Center are committed to providing quality care that meets the practice guidelines and ethical standards for psychologists and psychiatrists. As such, we work jointly with clients to achieve positive results, understanding that psychotherapy has both benefits and risks. One risk is remembering unpleasant events. Anxiety, guilt, depression, fear, anger, loneliness and/or feelings of helplessness can occur when one begins to explore current and past feelings. At the same time, psychotherapy can be of benefit to people who undertake it. It can lead to a significant reduction in stress, better relationships, and resolution of specific problems.

Oftentimes, clients come to therapy with difficulties that are best treated with brief interventions. This involves a time-limited, problem-focused and solution-oriented method of treatment. The best results can be expected when both the psychologist or psychiatrist and the client take an active role in assessing the current difficulties, agreeing on a successful outcome and planning creative solutions to meet your goals.

By signing below, you agree to participate with your practitioner in psychological or psychiatric treatment, exams, and/or diagnostic procedures, which at this time or in the future are advisable. Your signature also indicates that you understand that the purpose of these procedures will be explained to you upon request. All procedures are subject to your agreement. Finally, you understand that while the course of treatment is designed to be helpful, your practitioner can make no guarantee about the outcome of the treatment.

_____ _____

Client Signature Date

(If you are here with a child we need the following two signatures)

_____ _____

Signature (Mother) Date

_____ _____

Signature (Father) Date

OFFICE POLICIES

After Hours Coverage: In the event that you need to speak with someone immediately, please call the office. Twenty-four hour coverage is provided through our answering service. Please be aware that you may be speaking to a psychologist/psychiatrist other than me when you call after hours. You may also call your family physician or go to the nearest hospital emergency room.

Legal Proceedings and Court Involvement: If you are involved in, or anticipate being involved in, legal or court proceedings, please notify your psychologist/psychiatrist as soon as possible. It is important for the psychologist/psychiatrist to understand how, if at all, your involvement might affect your work together. Each psychologist/psychiatrist has individual policies concerning what type of court proceeding/legal involvement in which they are willing to participate.

In the event you are entering treatment because you have been asked to obtain a psychological/psychiatric evaluation it is important for you to know the difference between treatment and evaluation, and to recognize that treatment is not a substitute for an evaluation or an appropriate method to attain evaluation results. If you need an evaluation, your psychologist/psychiatrist can assist you in finding an appropriate provider.

Your psychologist/psychiatrist will not be party to any legal proceedings against current or former clients. Clients entering treatment are agreeing to not involve their psychologist/psychiatrist in legal/court proceedings or attempts to obtain records of treatment for legal/court proceedings when martial or family therapy has been unsuccessful in resolving disputes. In the event of a court proceedings, your psychologist/psychiatrist can only disclose information you have given consent to release, and cannot disclose information about family members or parties involved in treatment without their consent. This prevents misuse of your treatment for legal objectives.

Professional Fees and Billing Practices: The payment of all professional fees is the direct obligation of the client, regardless of any insurance policy coverage for psychological and psychiatric services. Our fee is based on prevailing standards in the community. As community standards change, our fees may change accordingly.

Currently, the psychologist's office fee is $125.00 for each session after your initial visit. The fee for the initial visit is $175.00 Fees may vary according to our contract with your insurance plan. An average session is scheduled for approximately 50 minutes

Currently, the office fee for psychiatric care is $125.00 for a 20 minutes session or $175.00 for a 45 minute session, after your first visit. The fee for the initial visit is $240.00. Fees may vary according to our contract with your insurance plan.

Your co-payment is due at each appointment. This co-pay is determined by your specific insurance benefit plan. The amount of your co-pay may change according to the length of your treatment. It is your responsibility to determine your deductible and co-payments and pay those. It is also your responsibility to obtain prior authorization for services (if necessary) through your insurance company. If any of the proposed services create an unacceptable financial burden, please talk with your practitioner before the service begins so acceptable arrangements can be made.

Fees are also charged for:

1) Telephone consultation time initiated by the client.
2) Time spent in letter or report writing on behalf of the client.
3) Appointments that are broken without notice or canceled/rescheduled with less than 24 hours notice.

My policy concerning missed appointments or late cancellations is to charge $ 25 session charge (please initial) _____ for each missed session. Insurance companies do not cover these charges. They are the clients' responsibility.

The psychiatrist's policy concerning missed appointments or late cancellations is to charge ½ of the appointment charge for each missed session.

We will bill your insurance company or EAP unless you instruct otherwise. You will receive a monthly statement from our office reflecting all unpaid charges, including those that have been submitted to the insurance company. In the event that your insurance company denies mental health services, please discuss the situation with your therapist. When you choose to continue treatment beyond the limits of insurance coverage, you become responsible for 100% of the bill. If an overpayment occurs, your credit will promptly be refunded to you. Please note: Clients choosing not to bill an insurance company will also receive monthly statements.

In the event the Center is unable to collect the necessary funds to settle a client account, this account may be turned over to an outside collection agency. Itemized fee statements are mailed to each client at the end of each month. Full payment or partial payment (if negotiated with your therapist) is expected by the end of the following month.

Grievances and Appeals: Most insurance companies have specific appeals and grievance procedures concerning the authorization process and or any complaints you might have about your care. Your psychologist/psychiatrist can assist you in obtaining information and forms you might need for either procedure. You may send any complaints about your care directly to the insurance company also. If you do have complaints or questions about your care, it is appropriate to first speak with your provider in an effort to resolve any differences

Your signature below acknowledges your receipt of these Office Policies and your agreement to the procedures that are explained.

_____ _____

Client Signature Date

(If you are here with a child we need the following two signatures)

_____ _____

Signature (Mother) Date

_____ _____

Signature (Father) Date

Revised 2-15-06 for web site