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Informed Consent Document

In order for therapy to begin, some guidelines must be set up so that everyone is aware of how therapy and sessions will work. I encourage you to read this document thoroughly and ask any and all questions you may have. This agreement is important in knowing and understanding what to expect from me as your child's therapist, and what your rights as a client are in our therapeutic relationship. There are certain limitations that are set by my professional association, the American Counseling Association (ACA) and those are outlined below. If at any time, you have questions or are dissatisfied with this agreement, please let me know, and this document can be discussed. You are free to terminate therapy at any time, but I would prefer if this were discussed beforehand, as sudden termination may have potentially negative effects. By signing this document, all parties acknowledge that they have read and understood this document and accept its terms and conditions.

Please feel free, at any time, to ask me any questions or talk with me about your concerns regarding your therapy. Your role is very important in the course and having input and support from your support system can help the therapy process.

Goals of Therapy:
The goals of therapy are to look at, and process, whatever the client wishes to work on. This can include: past trauma/abuse, behavioral concerns, emotional concerns, mood irregularities, social struggles, educational struggles, as well as any other concerns that are presenting a problem or struggle in daily living. I also offer therapy that can vary greatly in how directive the approach is. I support my clients in setting goals for their sessions and actively working towards the resolution of their concerns. When appropriate, homework may be given to the client as a way to take session material into their daily life.

Risks and Benefits:
Therapy in any form comes with risks and benefits attached. Some things that you should be aware of when you begin therapy are that some struggles may get worse before they get better and that progress may not be apparent all at once. The length of therapy differs for each individual client, so you should not be discouraged if you require more time in therapy. Some benefits of therapy may be that you feel that you have a safe place where you can say, do, and feel whatever you need to in your session.

My Responsibilities as Your Therapist:
I. Confidentiality:
I will at no time, except for a few exceptions described below, disclose your private health information or that of your child(ren). Anything discussed during our therapeutic relationship is completely confidential and privileged information. I will not release this information to any third parties without your express permission to do so, and you may revoke this permission at any time. If it is necessary to discuss your progress with any outside parties (such as school, medical , or mental health professionals), I will only speak to those individuals which have been added to the attached HIPAA form of outside professionals that you have given permission for me to have contact with regarding your treatment. Additionally, I will only disclose that information that is relevant to the specific party requesting the information.

There may be times when I discuss my work in supervision or consultation with fellow mental health professionals in the field. Supervision is designed to make sure that a therapist is able to work to the best of their ability and is not burned out. No names or specifics about a case will be discussed during this time, and the supervisory relationship is also bound by confidentiality.

The Federal Health Insurance Portability and Accountability Act (HIPAA) is designed to protect the release of your private health information. Under this law, all electronic transmission of information regarding your private health

information will be safeguarded using encrypted email, secure fax lines, and coded billing forms. This information will be kept in my office, under lock and key and no one will have access to this without my permission.

If you should choose to use an electronic means of reaching me, such as a phone call to my cell phone or through a private email account, you should be aware that these may not be absolutely confidential. All email correspondence (both from you and to you) will be printed and placed in your file, under strictest confidentiality.

Exceptions to Confidentiality
I am mandated as a professional in the State of Oregon to report certain information that may be released to me during our therapeutic relationship. If one of the following situations should arise, be advised that I am responsible for reporting them. Additionally, if my records are subpoenaed by the court, and a judge determines that our conversations (with both you or your child) are not confidential, then they will have access to your private health information that is pertinent to the court proceedings. Some situations may be:

1. If I have good reason to believe, or it is disclosed to me that my client has been abused, physically or sexually, that they are in immediate danger of harm, or that a different individual or vulnerable person is being abused, I am mandated as a professional to report this to the Department of Human Services, Child Protective Services, or local authorities within the first 24 hours of this information being disclosed.

2. If I have good reason to believe that you or your child will harm either your/themselves, someone else, or someone's property, I am mandated to report this. If a specific person is mentioned in this, I will attempt to contact said person and warn them of your/their intention to harm, and I will also contact the police if necessary.

Confidentiality in a Therapeutic Relationship: Your Child's Privacy in Therapy
As the parent(s) of a child in therapy, you are probably concerned about your child's well-being and would like to find out what is going on for your child. As in a therapeutic relationship with an adult, confidentiality between client and therapist is implied. In therapy, we acknowledge that the child is the client, and this ensures their privacy and respect to make decisions about their therapy. This does not mean that I will not share with you what your child says or does in therapy. Rather, I will discuss themes or patterns that I see emerging in our therapy sessions. I will keep you informed of any changes or important developments, but in order for your child to develop a trusting therapeutic relationship with me, I will not disclose everything that occurs in a session. Quite often, children will instead choose to share with you what occurred in a session, when they are ready to do so. It is important that we all recognize the autonomy and privacy of your child; so that they can work through whatever issues they need to. In time, they will most likely tell you, on their own, what they would like you to know.

However, as the legal guardian of this child, you are entitled to view their private health information. Any transcriptions of sessions, notes on sessions, and progress reports are also available if you should request them. Any requests for these records will involve a discussion around what dynamics are at play and to explore any and all potential reactions by the child upon hearing that their records were submitted to a legal guardian.

II. Documentation:
Some types of information that may be included in documentation are: client's current developmental level, both long and short-term goals of treatment, any information from a session that is relevant to these goals, any instances of touch (which will also be recorded on tapes of sessions), some themes of play and the materials and toys chosen during a session, photographs or drawings that were either created in a therapy session or are of things made during a session (sand tray designs or something built from toys that cannot be guaranteed to be the same for the next session), any consultation with other professionals involved in your care, any suicidal ideation or threats made during a session as well as how it was handled, as well as any aggression shown towards self or others, any observations I make about you with others in their lives, observations about the family dynamic and environment, and any conditions for termination. All of this private health information will be protected and secure.

III. Technology
There have been many wonderful advances in technology and social media. This is a constantly changing area and I do my best to stay abreast of the most current best practices as outlined by the Oregon Board of Licensed Professional Counselors and Therapist as well as the American Counseling Association. Currently I do not "Friend" clients on Facebook. I also do not engage in the practice of "googling" or searching for my clients through the

internet. I will utilize text messaging only as a way of appointment reminders and will text no confidential information at any time. This will be discussed with my clients and indicated in their permanent file. I may offer my clients the ability to video chat. This will be discussed upon between myself and my client ahead of time. If this option is chosen I will only use a video based chat platform that complies with HIPPA confidentiality protocols as well as has Voice Over Internet Protocols. The time, place, and technology used will be included in your file.

Fees and Charges:
My fee is:
-$150 initial consultation
-$100 hour long session
-$125 90 minute session
-$3 fee for any electronic payment through Visa, Master Card, American Express, or Discover

Therapy session length will be determined by your current level of functioning, attention span, and needs. The length of the therapy, overall, will depend on the client and the progress they make. If the client requires more or less time in therapy, that can certainly be arranged and it is not a cause for concern. Each client receives therapy as long as needed. We will be in regular contact about your progress and will make this decision together.

If therapy services are to be submitted to your insurance carrier, it must be submitted on your own. Currently I do not accept insurance plans. Please note, most insurance carriers request a diagnosis for therapy services and this will be discussed with your before any formal documentation is made.

Fees for missed appointments:
Appointments require a 24 hour cancellation. Any appointment not cancelled with 24 hours' notice will be billed at the full session rate. Appointments may be made up at the discretion of the therapist.

Concluding Statements: I hope that you have read through this document carefully and have discussed any questions you may have with me. I am looking forward to working with you and your child.

If you have discussed any and all questions and feel ready to do so, please sign below and return this document at our next meeting.

I/We give permission for our child(ren) _____ to participate in therapy with Corey May. I have read and understand this document and agree to its terms. I have discussed any and all questions and feel ready to do so, please sign below and return this document at our next meeting

_____	_____	_____
Client/Parent/Legal Guardian, Print Name	Signature	Date
_____	_____	_____
Client/Parent/Legal Guardian, Print Name	Signature	Date
_____	_____	_____
Client/Parent/Legal Guardian, Print Name	Signature	Date
_____	_____	_____
Corey May, MS, LPCI, NCC, Print Name	Signature	Date

HIPAA Consent to Contact Other Health Professionals

Name of Consumer _____ DOB: _____

I. HIPAA Privacy Rule

I hereby acknowledge that I am aware of the HIPAA Privacy Rule and have been offered a copy of Corey May's Statement of Confidentiality.

Signed: _____ Date: _____

Print Name: _____

II. Consent for Treatment and/or Services

I, as a client of Corey May, hereby authorize examinations, evaluations, tests, treatments and services to be provided as necessary. In signing this consent, I understand that my protected health information may be used for the purposes of treatment, payment, and operations.

Signed: _____ Date: _____

Print Name: _____

Relationship:_____

Consent to Release Information

Your signature below indicates the following:

 I authorize departments in which I receive services from Corey May to receive the minimum necessary of my health information.

 I authorize and direct the below named organization to release all or part of my health information, as necessary, to any person or corporation, including but not limited to insurance companies or any organization which may be financially liable for payment of any of the services that I have received.

 In accordance with Oregon State Archives Administrative Rule 166-400-0060, which sets the length of time a district must keep student records, FERPA (Family Educational Rights and Privacy Act) and The Document Retention, Security and Destruction Policy, I hereby authorize that my child's records be maintained in a secure location for 5 years after my child graduates or turns 18, at which time the records will be shredded, incinerated, or eliminated electronically. If consent is not given, the parent will contact Corey May to obtain the records.

I hereby request and give consent, to Corey May, to release or obtain my health information to, or from, the following individual (s), Groups (s), or Organization (s): (Complete below by writing the name and addresses as desired. Cross out any not used.)

Organization Name/ Provider	Address	Phone #	Info requested	Contact Person	Position