

CHRISTIAN WOLFF, MA ■ Licensed Psychologist Associate

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TREATMENT CONTRACT

I. Rights

You may discontinue treatment at anytime. There is nothing in this contract that requires you to start or to continue in therapy.

Confidentiality. You may review my “Notice of Privacy Practices” for additional information about the uses and disclosure of information. The information you share with me in treatment is confidential. This means I am legally and ethically bound to maintain your privacy and confidentiality. The following are legal exceptions to your legal right to confidentiality. I will inform you of any time when I think I will have to put one of these into effect.

1. If I have good reason to believe that a patient of mine will harm another person, I must attempt to inform the intended victim; I must also contact the police and ask them to protect the intended victim.
2. If I have good reason to believe that a patient of mine is abusing or neglecting a child or vulnerable adult, or if I have good reason to believe that a child in treatment has been abused, I must contact Child and/or Adult Protective Services within 48 hours.
3. If I believe you are in imminent danger of harming yourself, I may legally break confidentiality and call the police. I would explore all other options with you before I took this step.
4. If we have some individual sessions as a part of couples or family therapy, what is said in those individual sessions can and probably will be discussed in the following couples or family sessions. Do not tell me anything you wish kept secret from other family members who are in treatment with me.
5. I may have to release your records when ordered to do so by court subpoena. I will discuss this with you beforehand.
6. I may have to release certain clinical information regarding you to insurance carriers as required for payment or review of your claim.

Risks and benefits. You have the right to know the potential risks and benefits of the treatment you are receiving. Treatment has both benefits and risks. It requires an investment of your time and energy in order to make the process of treatment most successful. We will begin with a discussion of your needs and concerns and what it is you would like to accomplish by coming for treatment. Next, we will discuss a treatment plan in accordance with your goals and aims. Frequently, individuals go through periods in treatment which result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. Remember, you always retain the right to request changes in treatment or refuse/decline treatment at anytime.

Treatment works best if you are knowledgeable about your problems and diagnosis. You have the right to ask me questions about anything that happens in treatment. I am always willing to discuss how and why I have made my decisions as well as my diagnosis and understanding of your problems.

Treatment works best if we can work as a team. We will work together to establish the goals and duration of therapy, and you will have the right to discuss and change these at any time. Most insurance plans will provide payment for services which are determined to be “medically necessary,” and I will inform you of the medical necessity of your treatment. You have a right to participate in the discussion regarding the ending of our work together.

Emergencies. I am available by phone for emergencies by calling my regular number which is 503-284-4501. I will return the phone call as soon as possible. However, at times I cannot be reached for an emergency, you may call the Multnomah County Mental Health Crisis Line at 503-988-4888. If the emergency is life threatening, call 911.

If I am not able to help you with my services, you have the right to a referral to another treatment provider who may be better able to meet your needs.

II. Responsibilities

Attendance:

1. You are responsible for coming to your sessions at your scheduled time. If you are unable to keep an appointment, please notify me immediately. If an appointment is missed with less than a twenty-four hour notice, you will be billed for the session. Exceptions to this rule will be extremely rare. If you are billed for a missed session, it is unlikely that your insurance carrier will pay for this charge and you may have to pay this on your own.
2. You are responsible for telling me when you wish to conclude treatment.

Payment Method:

1. The client or their guardian is considered responsible for payment of professional fees. If we agree to bill a third party and that third party fails to make payments, I will notify you and arrange a payment schedule.
2. Payment of all required co-payments, deductible, and non-allowable charges will be made at the time of service. Presently, I am unable to accept credit cards or debit cards. Payment will need to be in the form of cash or check.

Specific fees are outlined on the Fee Agreement Form which you will need to sign.

Defaulted accounts may be sent to collection, and you may be responsible for payment of the cost of collection.

Insurance and third party payments. If you would like me to bill your insurance carrier, I will bill on a monthly basis, and you are responsible for payment of all co-payment, deductibles, and non-allowable charges for medically necessary treatment. Some insurance companies require pre-authorization of services.

By signing this treatment contract, the client and/or other responsible party agree to allow me to provide to their insurance carrier (if insurance is being used), any information necessary for the collection of fees from the insurance carrier.

By signing this treatment contract, the client and/or other responsible party agree that they have read it carefully, have understood its content, have been offered a copy, and agree to its terms. The client also agrees that they have read and understood my "Notice of Privacy Practices" and agree to participate in treatment under the terms set forth.

Signatures:

Client

Date

Other responsible party and relationship to the client Date

Witness

Date