Carolyn Hoffmann, Psy.D.
Licensed Clinical Psychologist
Wilsonville, OR
(503) 657-7200

CHILD CONSENT FORM

CONTRACT FOR PSYCHOLOGICAL SERVICES

Welcome to my practice. The following information highlights the business arrangements for treatment and should help you make an informed decision concerning treatment.

NATURE OF THE TREATMENT

Counseling can be a very life-enhancing process. Therapy often leads to better relationships, deeper understanding of the origins of conflict, solutions to specific problems, significant reduction in feelings of distress, and a general sense of well-being, contentment, and self-acceptance. I intend to make our professional contact maximally beneficial to you. It is my belief that individuals have the potential to grow and make adaptive changes at any stage of life.

Counseling is a joint process that requires active participation on your part including commitment, time, and effort. I have extensive experience providing clinical services to people who are dealing with a wide variety of emotional and interpersonal difficulties. However, if our work together leads to problems beyond my expertise, I will help you obtain the necessary services from the appropriate specialist.

Although counseling is generally beneficial, results cannot be guaranteed and there can be risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings, face unpleasant life events, thoughts, and beliefs, and develop increased awareness of values, experiences, and emotions. It is important to remember that the feelings you experience are likely normal and are an important part of the therapy process.

During our work together, all business is conducted directly with me. I answer my own phone calls and schedule my own appointments. While it is a professional service, it also involves a very personal relationship. Therefore, I encourage you to bring up any of your assumptions, problems, or possible negative side effects of our work together.

APPOINTMENTS

Therapy sessions are generally 60-minutes in length. Because the appointment is reserved for you, it will be necessary to charge for missed appointments and appointments that are cancelled without 24-hour advance notice. This fee is $65. No-shows and late cancellations that occur on a repeated basis (beyond 3 times) will result in my full fee being charged to you. Please note that insurance companies will not cover any portion of the fee for missed appointments. When it is necessary to cancel or reschedule an appointment and you are not able to reach me directly, please leave me a voicemail message or text your cancelation to my office number. All texts should be signed (even if you have texted me previously). This is because I do not save client phone numbers or text histories in my phone for confidentiality reasons. Please do not email me regarding cancelations as I do not check email as often and may not get a message of that sort within the 24-hour window.

MESSAGES

I am often not immediately available when you call. When I am unavailable, calls are answered via voicemail to protect your confidentiality and to give you the opportunity to leave messages of any length. I check my messages frequently throughout the day and am able to return most of my calls on the same day with the possible exception of weekends and holidays. If I am going to be unavailable for an extended period of time, I can provide you with the name of a colleague to contact in my absence.

EMERGENCIES

If you are unable to reach me and are experiencing a mental health emergency, please contact the 24-hour Clackamas County Crisis Line at (503) 655-8585 or call the nearest emergency room and ask for the mental health professional on call. If you are experiencing a mental health crisis and cannot reach me, please leave me a voice mail message and proceed to the emergency room of the hospital nearest to you.

CONFIDENTIALITY

Counseling is a private treatment, and I am committed to preserving your confidentiality to the fullest extent possible. In general, the law specifies that the communication between a patient and psychologist is private. I can only release information about our work to others with your authorization. However, there are certain exceptions to confidentiality that are legally mandated. Although these situations rarely occur in my practice, they are important for you to know about before starting treatment. There are four instances in which I cannot legally ensure confidentiality. They are: 1) instances of suspected child abuse, 2) instances of suspected elder abuse or abuse of a disabled person, 3) instances in which intent to commit a crime or intent to commit bodily harm to self or other(s) is made, and 4) when a patient introduces his or her mental condition as a defense or claim in a legal proceeding. If I believe that a patient has committed or is threatening serious bodily harm to someone, I will need to take protective actions. These actions could include contacting the police or an abuse reporting agency or notifying the potential victim. If the patient threatens to harm him/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. Also, in some child custody legal proceedings, a judge may order my testimony if he/she determines that the issues demand it. Finally, if you choose to use insurance to cover some of your treatment costs, the insurer will require you to authorize the release of certain clinical information about you and your treatment.

FEES

My fee is $220 for the intake session and $170 per 60-minute session thereafter. My clients are expected to pay for services when they are provided unless special arrangements are made. I encourage you to make out your check for payment in advance so that our entire time may be spent attending to your concerns. I charge the same amount for other psychological services you may need, although I break down the hourly cost if I work for periods of less than one hour. Other services include preparation of records or treatment summaries, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, participation in legal proceedings involving you, and any other services you may request of me.

MINORS

If you are a parent bringing your minor child (under the age of eighteen) in for treatment, the conditions of this agreement apply. However, please be aware that in order for treatment to be maximally beneficial, it is essential that your child be able to trust me completely. Therefore, in some cases (especially with adolescents), I will request that you agree to allow me to preserve the child's confidentiality and that you give up your right to access the child's treatment records. If you agree to this in the best interest of the child's treatment, I will provide you with general information about the child's progress or with as much detail as the child feels comfortable with me disclosing. However, I reserve the right to break the child's confidentiality and provide you with specific information about treatment at any time under the following circumstances: a) when I believe it is clinically warranted and in the best interest of the child's treatment progress, b) if the child's condition deteriorates or a risk of suicide develops and warrants inpatient treatment, or c) if the child experiences substance abuse issues that require detoxification, group, or inpatient treatment.

TERMINATION OF TREATMENT

The decision to terminate treatment will most likely occur naturally as your child experiences personal growth and achieves his/her treatment goals. As it was your decision to bring your child into therapy, it is also your choice to terminate therapy when you feel your child is no longer in need of services. While it will most likely be a decision that we make together, you are free to end the contract for treatment at any time.

I again welcome you and your child and look forward to a mutually rewarding process together.

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CONTRACT FOR PSYCHOLOGICAL SERVICES

CONSENT TO TREAMENT:

Signing below indicates the following:

1) I have read and received a copy of the Contract for Psychological Services with Dr. Hoffmann and agree to its terms.

2) I acknowledge that I have received a copy of the Notice of Privacy Practices and agree to its terms.

____
Name

____
Signature

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Date

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Carolyn Hoffmann, Psy.D.