INFORMED CONSENT STATEMENT

Colleen Moloney, LCSW: I am a Clinical Social worker in private practice. I have a masters degree in social work and have been a Licensed Clinical Social Worker in Oregon since 1994. I adhere to the National Association of Social Workers Code of Ethics. The following information answers some important and frequently asked questions concerning my practice. Please read this form carefully and let me know if you need more information about policies or treatment.

Confidentiality/Client Rights: I abide by the laws and ethical principles that govern privilege and confidentiality. I will not discuss any information about you with anyone without your written permission by way of a signed Authorization to Disclose Medical Records. There are some exceptions to this standard which are also noted in the Notice of Privacy Practices:

- I am legally required to act so as to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
- I am legally required to report cases of ongoing child, elder and disabled person abuse.
- I may release information, upon request to the non-custodial parent of children under the age of 18.
- I may release information to parents, if the client is a minor under the age of 14.
- I consult with colleagues about my work. This is kept confidential, without using your name or identifying information.
- I may have to release clinical information regarding you to your insurance carrier as required for authorization, payment of your claim, or quality assurance review.

- I may have to release your records when ordered to do so by court subpoena. I do not do court work, if you are involved in a court case or anticipate a court case I am the wrong person to work with. However, I will discuss this with you beforehand and request a written release of information from you, if I judge this to be in your best interest.
  (________)**initial here**

It is important that you discuss any question or concerns that you may have now or in the future regarding exceptions to confidentiality. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Appointments and Fees:
Assessment/Initial Session $220 (55 minutes)
Follow up Sessions $185 (55 minutes)

Couple Assessment/Initial Session $440 (1 hour 45 mins)
Follow up Sessions $370 (1 hour 45 mins)
Couples sessions are a minimum of 1 hour 45 mins
Frequent or extended telephone calls and reports or letters are billed at my usual therapy rate, with a 15 minute minimum charge. **Phone calls and letters/reports are not billable to insurance.**

Your co-payment is due at the time of service unless other arrangements are made in advance (or full payment, if insurance is not used or your deductible is not satisfied).

There is a 50% charge for the first appointment canceled less than 48 business hours in advance. Thereafter, missed appointments are charged in full. (To cancel an appt for Monday you would need to cancel Friday to avoid paying the cancellation fee) If you are ill or have an unavoidable emergency and cancel prior to your appointment, there is no charge. **Insurance does not cover late canceled or missed appointments.** Payment for late canceled or missed appointments will be due prior to the next appointment. (_____) **initial here**

For clients who have insurance coverage, claims are submitted on a regular basis unless you request otherwise. **In the event your insurance does not pay for your treatment, you will be responsible for payment. (______) initial here**

Insurance benefits have become increasingly complex. It is sometimes difficult to determine exactly how much mental health coverage is available. In addition "Managed Health Care" plans such as HMOs and PPOs often require prior authorization in order to reimburse for services.

My office will send you a monthly statement if there is an outstanding balance which your insurance is not expected to pay. Payment of any outstanding client balance is due within two weeks.

Legal/Court Involvement: **If you enter into treatment with me, you are agreeing not to involve me in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings.** This prevents misuse of your treatment for legal objectives. My goal is to support you in achieving therapy goals, not to address legal issues that require an adversarial approach. (_______)**initial here**

If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your legal involvement might affect our work together. It is important for you to recognize that treatment is not an appropriate way to obtain evaluative results. If you need a formal psychological evaluation, I will be happy to assist you to find a provider who offers this service.

In the event you do require my testimony or involvement in any non adversarial aspects of legal/court proceedings, I will do so only with your written consent. I will be unable to disclose information pertaining to other family members or parties involved in treatment with out their written consent to disclose this information.

In situations requiring court involvement, my fee is $300 per hour for court appearances, preparation for court testimony including, but not limited to, consulting with attorneys, reviewing the file, report/letter writing and time spent traveling to court and waiting to testify. There are additional fees for parking and mileage. A retainer for court expenses will be due and payable a minimum of two weeks prior to a scheduled court appearance. In the event of a settlement or cancellation of the trial/hearing with less than 24 hours notice, a charge will be levied for those hours originally set aside for the trial/hearing. These services are not reimbursable by your medical insurance.

Treatment Philosophy: Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods in therapy which result in emotional discomfort, changes in

relationships or temporary worsening of their symptoms. This should subside as the work progresses. You will always retain the right to request changes in treatment or to refuse treatment at any time.

Contacting Me: I am often not immediately available by telephone. When I am unavailable, my telephone is answered by a confidential voice mail that I monitor frequently. Please inform me of some times that may be best to reach you.

Emergencies: Because I am not readily available by phone, I am not the best person to call in an emergency. Please contact Multnomah Mental Health Crisis Line at 503-988-4888, or go to the nearest emergency room.

Grievance Procedure: If at any time you are dissatisfied with your treatment, please discuss your concerns with me directly so we can work together to resolve them. If, after doing so, you would like a referral to a different therapist, I would be happy to assist you. If you ever have serious concerns that are not resolved successfully with me directly, you may call the Oregon Board of Clinical Social Workers.

Consent to Treatment: Signature(s) below indicate that I /we have read and understand the above consent to treatment with Colleen Moloney, LCSW, under the conditions specified above. I/we specifically authorize the release of my clinical record information to Amber Mills for coordination with my insurance company for the purpose of payment, health care credentialing, utilization review and quality assurance review. In the event that treatment is for a minor child, I hereby give my consent to treatment and affirm that I am their legal guardian with authority to authorize mental health treatment.

Client Name (Please Print)____

Signature (Client or Legal Guardian)______________________________Date_____

Client Name (Please Print)____

Signature (Client or Legal Guardian)______________________________Date_____

Acceptance of Financial Responsibility: I assume financial responsibility for any balance on my account. I will make co-payments and pay amounts owed toward my deductible at the time of each session unless alternative arrangements have been made. I understand and agree to pay 50% of the session fee for the first appointment canceled less than 24 hours in advance and 100% for missed appointments thereafter.

Client Name (Please Print)____

Signature____Date___________

Client Name (Please Print)____

Signature____Date___________