BRITT ANDERSON, PH.D.
INDEPENDENT PRACTIONER

INFORMED CONSENT STATEMENT & OFFICE POLICY

Please keep one copy of this office policy statement for your records. A second copy, signed and dated, will be kept in your file. It is very important that you read the entire statement carefully and ask any questions that you may have before signing.

General Standards

As a clinical psychologist licensed by the Oregon Board of Psychologists Examiners, I subscribe to the APA Revised Ethical principles.

I work from a cognitive-behavioral and humanistic orientation. I recognize that change in behavior can lead to changes in thoughts and beliefs and, conversely, that changing thoughts and beliefs can lead to behavior change. I work collaboratively with my clients as they learn to handle difficult emotions, relationship issues, and problematic behaviors.

Occasionally individuals may go through periods in therapy that may result in increased emotional discomfort, changes in their relationships, or a temporary worsening of their symptoms. These periods should subside as the work progresses. Remember that you always retain the right to request changes in treatment or to refuse treatment. I encourage you to discuss any personal doubts, concerns, or discomforts regarding your treatment, at any time.

Confidentiality

I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose to anyone anything you tell me, not even the fact that you are a client, without your written permission via a signed release of information form. There are a few exceptions to these standards:

1. It is legally required of me to act so as to prevent physical harm to others or to society when there is "clear and imminent" danger of that happening.
2. I am ethically bound to act to protect you or others from harm.
3. I am ethically bound to report cases of ongoing child, elder, and disabled abuse.
4. I may have to release clinical information regarding your treatment to insurance carriers as required for payment or review of your claim.
5. I may have to release your records when ordered to do so by court subpoena. However, I will discuss the details of privilege with you beforehand and request a written release from you if I judge this to be in your best interest.
6. I may use electronic transmission to send treatment plans, reports or evaluations to your insurance company, specific agencies or other providers.
7. Email correspondence is not confidential.

Email and Data Security

It is important to be aware that email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. A non-encrypted email is even more vulnerable to unauthorized access. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell-phone or faxes. If you communicate confidential or highly private information via email, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted. However, I will not respond to emails of a clinical nature until the next scheduled session. If you require a more immediate response, leave a confidential voicemail. Please note that emails are part of your medical records. **Do not use email for emergencies.** Due to computer or network problems, emails may not be deliverable and I may not check my emails daily.

The data on my professional hard drive and smart phone is password protected and encrypted.

Couple/Marital Therapy

By signing this form you are acknowledging that both partners have agreed to participate in couple/marital therapy and **both partners are considered my clients**.

Both parties involved in couple/marital therapy understand that I will not agree to keep secrets between them. Any information provided to me, regardless of whether the partner/spouse was present, may be either withheld or disclosed to the other party at my discretion.

Psychotherapy notes and all documents pertaining to treatment will be kept in one file under both partners' names. Both understand and agree that in order to keep proper records, I may make written record of any information provided by either party, or any observation made of either party's behavior.

Either partner/spouse may access the file, including notes pertaining to the other party, with exceptions as allowed or required by law. In making this agreement, it is recognized that either party might further disclose information obtained from their file and that I have no control over such re-release of information. If there is a request for an "outside" third party to access the file or obtain copies of records, **signatures of both partners/spouses will be required in order to release the requested information**.

Both parties involved in couple/marital therapy agree to my office policies, including payment responsibilities and additional confidentiality provisions.

Court Testimony

It is important for you to know that I do not wish to be a party to legal proceedings against current or former clients. My goal is to support my clients to achieve therapy goals, not to address legal issues that require an adversarial approach. Clients entering treatment are agreeing not to involve me in

legal/court proceedings or attempt to obtain records of treatment for legal/court proceedings when therapy has been unsuccessful at resolving disputes. This prevents the misuse of your treatment for legal objectives.

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 involvement in these proceedings might affect our work together. Also, entering into therapy is not the same as a forensic evaluation. In the event that you need such an evaluation, I would be willing to assist you in finding a provider that offers this service.

Appointments

Therapy sessions are arranged by appointment only. The initial consultation is 60 minutes in length and subsequent sessions are 45-50 minutes in length. If I am late I will make up the missed time or prorate your bill. If you are late, you will lose that portion of time from your session. Cancellation of sessions should be avoided. If you need to cancel an individual therapy appointment, you will not be charged for the appointment if you notify me 24 hours in advance of the scheduled appointment. **No show/no call or late cancelled sessions will be charged to you at full fee. Fees for missed sessions are not reimbursable by insurance companies.** Cancellations can be phoned into the office any time, day or night.

Termination

Should you not schedule an appointment for a period of 60 days and make no arrangement in writing with me, you will no longer be considered an active client of mine and therefore have terminated treatment with me. If you "no show"/"late cancel" for two consecutive appointments or "no show"/"late cancel" for one appointment without rescheduling within 30 days, you will be considered to have terminated treatment with me. Failure to pay for services will result in discontinuation of treatment. Failure to follow treatment recommendations or lack of progress in treatment may also result in termination of treatment and/or referral to alternative treatment options.

Telephone Calls and Emergencies

My voice mail service enables you to call my office at any time, day or night, and leave a message for a return call. I check my phone messages regularly and try to return calls within one business day. If I am out of the office and not checking voicemail, I will make this information available. Please do not use email for emergencies. While I check my phone messages during regular office hours, I do not always check my emails frequently. In the case of a life-threatening emergency call the Crisis Line at 503-988-4888 (Multnomah County), 503-291-9111 (Washington County), 503- 655-8401(Clackamas County), or go to the nearest hospital emergency room.

Fees

My fees for therapeutic services are the following: $200 per Intake session, $160 per Standard (38-52 minute) Individual session, $175 per Extended (53-60 minute) Individual session, and/or $175 per

Couples/Family session.

You are agreeing to pay for all services provided prior to the discontinuation of treatment. You can discontinue treatment at any time by phone or in person.

The contract for professional services and payment is with you. If you choose to use your health insurance coverage, I will submit claims on your behalf. You are asked to pay your co-payment or non-covered amounts at the time of service. Mental health reimbursement policies differ dramatically from one third-party contract to another. It is often difficult to predict the services and fees different plans will cover. For this reason, it is important to discuss these issues in your early sessions or when there is any change in your insurance to avoid confusion and problems that could interfere with our work together. Regardless of the insurance company's handling of the claim, you are responsible for all fees.

Consent to Treatment

I have read the Informed Consent Statement and Office Policy form. I have had an opportunity to ask questions about the information provided. I understand my rights to privacy, the exceptions to my rights to privacy, and that there are risks associated with treatment.

_____	_____	_____	_____
Signature of Partner/Spouse	Date	Signature of Partner/Spouse	Date
_____		_____	
Printed Name		Printed Name	

I, the therapist, have discussed the issues above with the clients and provided a copy for their records.

_____ _____

Signature of Therapist Date

CLIENT INFORMATION FORM

SPOUSE/PARTNER #1:

Name: _____

Address:_____

Phone: (Home/Cell) _____ (Work) _____
Message OK? Yes/ No Message OK? Yes/ No

Date of Birth:_____ Age ____ Gender: M____ F ___ SS#_____

Marital Status_____

Family Members

Name	Age	Gender	Relationship

Employer: _____Occupation:_____

Emergency contact_____
Name Phone Number Relationship

Please describe your ethnic, cultural, and/or religious background:

_____

Describe your primary reason for seeking therapy at this time:

_____

_____

Who referred you to this office?_____

Client or authorized person's signature: I authorize Britt Anderson, Ph.D. to make contact with the referral source to thank him/her and let him/her know contact has been made.

_____ _____
Signature Date

Are you currently involved in or do you anticipate involvement in any legal proceedings?

Yes ☐ No ☐ If yes, please explain:_____

PROVIDER INFORMATION

Primary Medical Practictioner_____
Phone_____
Have you had a physical exam within the past year? Yes ☐ No ☐
Do you authorize contact with your practitioner regarding your treatment? Yes ☐ No☐

Are you currently taking medications for psychiatric or emotional problems? Yes ☐ No☐
If so, please provide contact information for your prescriber:

Prescriber _____Date of last visit_____
Phone_____
Do you authorize contact with your prescriber regarding your treatment? Yes ☐ No☐

Do you have other Behavioral Health Specialists, participate in therapeutic/support groups, or access community resources for mental health? Yes ☐ No ☐

If so, please list those resources here:
1._____Phone_____
Do you authorize contact with this resource regarding your treatment? Yes ☐ No☐

2._____Phone_____
Do you authorize contact with this resource regarding your treatment? Yes ☐ No☐

3._____Phone_____
Do you authorize contact with this resource regarding your treatment? Yes ☐ No☐

Have you received therapy in the past? Yes ☐ No ☐
If so, please list the names of your providers and approximate dates of treatment below:

_____
_____
_____
_____
_____

HEALTH INFORMATION

Current health concerns or illnesses (include allergies):

_____

_____

Past medical problems and surgeries:

_____

_____

Please list any prescriptions or over the counter medicines that you take regularly. Please include **dosage** and **reason** for medication._____

_____

_____

Are there any general medical illnesses that run in your family (such as diabetes, heart disease, and others).

_____

Do you currently smoke cigarettes and/or use other nicotine products? Yes ☐ No ☐

If yes, please note the quantity and type of use:

_____

Did you smoke cigarettes and/or use other nicotine products <u>in the past</u>? Yes ☐ No ☐

Do you drink caffeine? Yes ☐ No ☐

If yes, please describe type/frequency:

_____

Do you currently consume alcohol? Yes ☐ No ☐

If yes, list average number of drinks per occasion: _____ days per week:_____

What is the maximum amount of drinks consumed **during one occasion** in the past year:

_____

Do you have a history of problematic use of alcohol? Yes ☐ No ☐

Have family members or friends expressed concern about your drinking? Yes ☐ No ☐

Do you currently use non-prescribed/street drugs? Yes ☐ No ☐

Do you have a history of problematic use of prescription/non-prescription drugs?

Yes ☐ No ☐

Have you had any previous treatment for alcohol or substance use/abuse? Yes ☐ No ☐

Do you have a family history of alcohol or drug problems Yes ☐ No ☐
If yes, please describe:

_____

_____

Are you having any problems with your sleep habits? Yes ☐ No ☐
If yes, please describe:

_____

Are you having difficulty with appetite or eating habits? Yes ☐ No ☐
If yes, please describe:

_____

Have you experienced significant weight change in the last 2 months? Yes ☐ No ☐

If yes, please describe:

_____

Do you exercise regularly? Yes ☐ No ☐

If yes, please describe type/frequency:

_____

Have you ever had thoughts of wanting to end your life? Yes ☐ No ☐

If yes, when?:_____

Have you ever been hospitalized for mental health concerns? Yes ☐ No ☐

If yes, please describe:

_____

_____

Have you ever attempted to harm yourself? Yes ☐ No ☐

If yes, when?:_____

Have you had serious thoughts of harming another person? Yes ☐ No ☐

If yes, when?:_____

Have you ever acted in a violent or abusive manner towards others? Yes ☐ No ☐

Is there any violence or other abuse in your home that concerns you? Yes ☐ No ☐

Was there any violence or other abuse in your home growing up? Yes ☐ No ☐

Have you ever been convicted of a crime? Yes ☐ No ☐

Are there any firearms in your current place of residence? Yes ☐ No ☐

Have family members been diagnosed/treated for mental health conditions? Yes ☐ No ☐
If yes, please list:

_____

_____

_____

SPOUSE/PARTNER #2:

Name: _____

Address:_____

Phone: (Home/Cell) _____ (Work) _____
Message OK? Yes/ No Message OK? Yes/ No

Date of Birth:_____ Age ____ Gender: M____ F ___ SS#_____

Marital Status_____

Family Members
Name Age Gender Relationship

_____

_____

Employer: _____Occupation:_____

Emergency contact_____
Name Phone Number Relationship

Please describe your ethnic, cultural, and/or religious background:

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Describe your primary reason for seeking therapy at this time:
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Who referred you to this office?_____

Client or authorized person's signature: I authorize Britt Anderson, Ph.D. to make contact with the referral source to thank him/her and let him/her know contact has been made.

_____ _____
Signature Date

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Yes ☐ No ☐ If yes, please explain:_____

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_____

Past medical problems and surgeries:

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_____

Please list any prescriptions or over the counter medicines that you take regularly. Please include **dosage** and **reason** for medication._____

_____

_____

Are there any general medical illnesses that run in your family (such as diabetes, heart disease, and others).

_____

Do you currently smoke cigarettes and/or use other nicotine products? Yes ☐ No ☐

If yes, please note the quantity and type of use:

_____

Did you smoke cigarettes and/or use other nicotine products <u>in the past</u>? Yes ☐ No ☐

Do you drink caffeine? Yes ☐ No ☐

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Do you currently use non-prescribed/street drugs? Yes ☐ No ☐

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Yes ☐ No ☐

Have you had any previous treatment for alcohol or substance use/abuse? Yes ☐ No ☐

Do you have a family history of alcohol or drug problems Yes ☐ No ☐
If yes, please describe:

_____

_____

Are you having any problems with your sleep habits? Yes ☐ No ☐
If yes, please describe:

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If yes, please describe:

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Do you exercise regularly? Yes ☐ No ☐

If yes, please describe type/frequency:

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Have you ever had thoughts of wanting to end your life? Yes ☐ No ☐

If yes, when?:_____

Have you ever been hospitalized for mental health concerns? Yes ☐ No ☐

If yes, please describe:

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Have you ever attempted to harm yourself? Yes ☐ No ☐

If yes, when?:_____

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Is there any violence or other abuse in your home that concerns you? Yes ☐ No ☐

Was there any violence or other abuse in your home growing up? Yes ☐ No ☐

Have you ever been convicted of a crime? Yes ☐ No ☐

Are there any firearms in your current place of residence? Yes ☐ No ☐

Have family members been diagnosed/treated for mental health conditions? Yes ☐ No ☐
If yes, please list:

_____

_____

_____

INSURANCE/BILLING INFORMATION

A. Payment Plan- We agree that payments or copays for services are due at the time of service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. Please initial the preferred option.

_____I intend to pay in full for the session or co-payment at the time services are rendered with check/cash. My credit card will be charged for any payments 30 days or more in arrears.

_____Charge my credit card for each session or co-payment at the time of service.

Finally, we understand that no show or late cancelled sessions (less than 24 hours notice) will be charged to me at full fee.

_____I authorize that the fee for any late cancelled/no show sessions will be charged to my credit card.

B. Credit Card Information- Required
I authorize Britt Anderson, Ph.D. to charge this account for services according to the payment plan agreed above:

Card Number_____

V/MC Expiration Date:(Mo./Yr.)_____

Name of Card holder:_____

Signature of Cardholder:_____

Address of Cardholder:
_____

INSURANCE PORTABILITY AND ACCOUNTABILITY ACT FOR THE OFFICE AND PRACTICE OF BRITT ANDERSON, PH.D.

The notice below describes how medical information about you may be used and disclosed and how you can get access to this information.

It is given to you, _____ on this date_____. It is yours to keep and refer to as needed.

Any questions regarding this document can be directed to the provider, Britt Anderson, Ph.D. at (503) 977-7925.

By signing this form, I agree that I have been provided with a copy of the Notice of Privacy Practices for the office and practice of Britt Anderson, Ph.D.

_____	_____	_____
Partner/Spouse Signature	Printed Name of Partner/Spouse	Date
_____	Britt Anderson, Ph.D.	_____
Provider Signature	Printed Name of Provider	Date

The notice below describes how medical information about you may be used and disclosed and how you can get access to this information.

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Any questions regarding this document can be directed to the provider, Britt Anderson, Ph.D. at (503) 977-7925.

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_____	_____	_____
Partner/Spouse Signature	Printed Name of Partner/Spouse	Date
_____	Britt Anderson, Ph.D.	_____
Provider Signature	Printed Name of Provider	Date

BRITT ANDERSON, PH.D.
04 SW HAMILTON STREET
PORTLAND, OR 97239

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE ***REVIEW IT CAREFULLY.***

I. **Who will follow this notice.** This notice describes Britt Anderson's services, practices and that of our workforce. The workforce includes employees, volunteers and others who work for Britt Anderson, Ph.D. Includes services based at the main clinic and other satellite facilities.

II. **We have a legal duty to safeguard your protected health information (PHI).** We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. Our employees are required to maintain the confidentiality of your PHI, and we have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change this notice and our privacy policies. Any changes will apply to PHI we already have. Before we make an important change to our policies, we will change this notice and post a new notice in waiting areas of our facilities. You can also request a copy of this notice at the front desk of our facilities.

III. **How we may use and disclose your protected health information.** We may use and disclose your PHI without your prior written permission. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

1. **For Treatment.** This is the most important use and disclosure of your PHI. Our physicians, nurses and other clinicians use and disclose your PHI to diagnose, evaluate, coordinate and manage your care. We may disclose your PHI among clinicians and other staff who work with Britt Anderson, Ph.D. We may also disclose your PHI to another health care provider. Your primary care physician for example.
2. **For Payment**. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the services we provided to you. For Medicaid clients or low-income clients on a sliding fee schedule, we will also provide demographic and service information to Oregon State Mental Health Division.
3. **For Operations.** We may disclose your PHI in order to operate this mental health center. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.
4. **For Appointment Reminders.** We may use and disclose your PHI to contact you to remind you of your appointment.
5. **For Treatment Alternatives.** We may contact you to describe services we offer; for treatment; for case management and care coordination or to recommend treatment options. For example we may tell you about a new therapy group that may be appropriate for your treatment.
6. **To Business Associates.** We may contract with business associates to perform certain functions or activities on our behalf such as payment and health care operations. The business associates must agree to safeguard your PHI.
7. **Specific types of PHI.** There are stricter requirements for use and disclosure of some types of PHI, for example drug and alcohol addiction treatment information and HIV information. However, there are still circumstances in which these types of information may be used or disclosed without your authorization. If you become a patient in our chemical dependency program we will give you specific information about your privacy rights for that program.
8. **For Disaster Relief.** We may disclose your name, city of residence, age, gender and general condition to a public or private disaster relief organization to assist disaster relief efforts, unless you object at the time.
9. **For Public Health Activities.** Many functions performed or authorized by government agencies promote and protect the public's health and may require us to disclose your PHI. For example we have an obligation to report certain diseases or exposure to disease, injuries, conditions and vital events such as deaths. We may use and disclose your PHI as needed to comply with federal and state laws governing workplace safety.
10. **For Health Oversight.** As a health care provider we are subject to oversight conducted by federal and state agencies. These agencies may conduct audits of our operations and activities and in that process; they may review your PHI.

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11. **For Worker's Compensation.** We may use and disclose your PHI to comply with workers' compensation laws by providing information to administrators, insurance carriers or others responsible for evaluating your claim for benefits.
12. **For Military Activity and National Security.** We may use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to carry out military missions. We may also disclose your PHI to authorized federal officials for national security and intelligence activities or for protection of the President and other government officials and dignitaries.
13. **For Fundraising.** We may use or disclose PHI to contact you to raise funds for our organization.
14. **As Required by Law.** In some circumstances federal or state law requires that we disclose your PHI. For example, the Secretary of the Department of Health and Human Services may review our compliance efforts, which may include seeing your PHI.
15. **For lawsuits and other legal disputes**. We may use and disclose PHI if responding to a court or administrative order, a subpoena, or a discovery request. We may also use and disclose PHI to the extent permitted by law without your authorization to defend a lawsuit or arbitration.
16. **For Law Enforcement.** We may disclose PHI to authorized officials for law enforcement purposes, for example to respond to a search warrant, report a crime on our premises or help identify or locate someone.
17. **For Serious Threat to Health or Safety.** If we believe it is necessary to avoid a serious threat to your health or safety or to someone else's.
18. **For Abuse and Neglect.** We may disclose PHI to the appropriate authority to report suspected child abuse or neglect or to identify suspected victims of abuse, neglect, or domestic violence.
19. **To Coroners, Medical Examiners or Funeral Directors.** We may disclose PHI to a coroner or medical examiner to determine cause of death or for other official duties.
20. **Inmates.** Under the federal law that requires us to give you this notice, inmates do not have the same rights to control their PHI as other individuals. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your PHI to them for certain purposes, for example to protect your health or safety or someone else's.

Except for those uses and disclosures described above, will not use or disclose your PHI without your written authorization. You may revoke that authorization by notifying us in writing at any time. The revocation will not apply to any authorized use or disclosure that took place before we received your revocation.

IV. **What rights you have regarding your PHI.**

1. **The right to see and get copies of your PHI. In** general you have the right to see and receive copies of the PHI in your medical record or billing records. If you wish to see or receive such records please write to Britt Anderson, Ph.D., 04 SW Hamilton St., Portland, OR 97239. We will respond to you within 15 days after receiving your written request. We will charge you the standard copying fees allowed by Oregon State law. In certain situations, we may deny your request. If we do, we will tell you in writing, our reasons for the denial and explain your right to have the denial reviewed.
2. **The right to choose how we send PHI to you.** You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, email instead of regular mail). When we can reasonably and lawfully agree to your request we will. We are permitted to charge you for any additional costs incurred by granting your request.
3. **The right to correct or update your PHI.** If you believe there is a mistake in your PHI or that important information is missing, you may request on writing that we correct or add to the record. Send your request to Privacy Officer, Britt Anderson, Ph.D., 04 SW Hamilton St., Portland, OR 97239. We will respond in writing. If we approve your request we will make the correction or addition. If we deny your request we will tell you why and explain your right to file a written statement of disagreement.
4. **The right to an accounting of disclosures of PHI.** You may ask for a list of. disclosures of your PHI. Write to Britt Anderson, Ph.D. at 04 SW Hamilton St., Portland, OR 97239. The list will not include disclosures we have made for treatment, payment and health care operations, disclosures that occurred' prior to July 2004, disclosure for which Britt Anderson, Ph.D. had a signed authorization, disclosures of your PHI to you; disclosures for notifications for disaster relief purposes; or disclosure to persons involved in your _. care.
5. **The right to request limits on uses and disclosures of your PHI.** Britt Anderson, Ph.D. will attempt to honor your right to limit use of your PHI, but may not be able to meet all requests. You may not limit the uses and disclosures that we are legally required or allowed to make.

V. **How to contact us about this notice or to complain about our privacy practices.** If you have any questions about this notice please contact our Privacy Officer at (503) 977-7925. If you want to lodge a complaint about our privacy practices please call our Customer Service Representative at (503) 977-7925. You may also notify the Secretary of the Department of Human Services (HHS): Office of Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20202.

VI. **Effective date of this notice.** This notice went into effect July 2004.

Britt Anderson, Ph.D.
Notice of Privacy Practices
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