Paula Levinrad, LCSW, CADC I

INFORMED CONSENT STATEMENT

I. Treatment Philosophy

The following answers some important and frequently asked questions concerning my practice. Please read this information carefully and let me know if there is any part you do not understand.

Psychotherapy has both benefits and risks. It also requires an investment of your time and energy in order to make the process of therapy most successful. I will begin with an evaluation of your needs. Next, we will develop and discuss a treatment plan in accordance with your goals and aims. Occasionally, individuals may go through periods in therapy that may 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 to refuse treatment at any time.

II. Health Insurance

If you are using a health insurance benefit as payment for these services, you need to be aware of what this means. Your health plan requires cooperation between client, provider and insurance company to provide services as efficiently as possible.

Health insurance companies usually limit mental health coverage to:

1) services that are determined to be "medically necessary". Medically necessary may be defined as presentation of a covered DSM IV Axis I diagnosis. (These are acute symptoms.)
2) conditions that are able to be treated by short-term, problem-focused, goal-oriented approaches wherever possible.

This means your insurance company will cover a limited number of office sessions to work on your problem as intensely as possible with the focus of eliminating acute symptoms. I am contracted with your insurance company to provide my services within these conditions. This practice reviews cases for quality assurance. Your case may be reviewed by a utilization review/quality assurance group set up by the insurance company or members of my practice. I will maintain your confidentiality in this process.

III. Office Policies

Appointments:

Sessions are arranged by appointment. If I am late, I will make up the missed time or adjust the bill accordingly. If a client is late, the full fee may be charged. If, because of unavoidable circumstances, an appointment is missed, there is no charge provided the appointment is cancelled at lease 24 hours prior to the appointment. Appointments, which are missed or cancelled with less than a 24 hour prior notice may be charged at the full fee. Cancellations can be phoned in to my answering service 24 hours a day. Monday appointments must be cancelled by Friday.

Emergency coverage:

In cases of emergency I can be reached through my answering service at 343-1937, press 0 for an operator. If I am not available you will be offered another on-call therapist. You may also consider calling your family physician or White Bird Clinic 24-hour Crisis Counseling at 687-4000 or go directly to your local emergency room (Sacred Heart Emergency Department at 686-6931)

IV. Confidentiality

I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose to anyone anything you tell me, nor even the fact that I have seen you without your written permission by way of a signed release of information form. There are some exceptions to this standard:

It is legally required of me that I 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 abuse.
- I may have to release clinical information regarding you to insurance carriers as required for payment or review of your claim.
- I may have to release your records when ordered to do so by court subpoena. However, I will discuss this with you beforehand and request a written release from you if I judge this to be in your best interest.
- On occasion, clinicians consult with colleagues about their work. If your case were ever discussed, it would be confidential and without your name or identifying information.
- I may release your records for an independent review as required by your health plan for the purpose of quality assurance.

Release of Information

Please sign below to show that you have read and understand this Information Consent Statement and that you authorize the release of your clinical record information to your insurance company for the purpose of healthcare credentialing, utilization review and quality assurance review.

____________________________________ _______________

Signature Date

____________________________________ _______________

Signature of Parent, Guardian or Legal Representative Date