Nate Wilson-Traisman Counseling

Individual, Couples, & Family Therapy

Basic Information Sheet and Consent for Treatment

This form provides you with information that you may need in order to make an informed choice regarding your counseling. If you have any questions please do not hesitate to ask.

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. If you would like me to speak with someone you will need to sign a release of information form identifying who it is you would like me to speak with and the information to disclose. I will release information to any agency/ person you specify unless I conclude that releasing such information might be harmful in any way. Also please note that e-mail and cell phone communications can be relatively easily accessed by unauthorized people and therefore, privacy and confidentiality can be compromised. There are times when I will consult with other professionals about concerns or the course of treatment, your identity will always be kept confidential and any identifying information will be changed or removed from the discussion. There are some situations in which I am allowed to break confidentiality and those include:

- When there is a reasonable suspicion of child, dependent or elder, abuse or neglect
- When you are in imminent risk of committing suicide, in danger of seriously physically harming someone else or are fully unable to care for yourself.
- And under the direct orders of a court judge.

Communication Between Sessions: I am generally available during standard office hours, M-F from 9am-5pm. I do my best to respond to all client contact within one business day. It is possible you may choose to communicate with me via email or text message. Please understand that these modes of communication are not HIPAA compliant, and it's advised that these methods of communication be used strictly for scheduling purposes. If you choose to communicate with your therapist via email or text message, you understand you are engaging in an unsecure method of communication, and your confidentiality could be compromised.

If you would like to communicate with me via email and/or text message, please initial here _____

Additionally, I will only respond to emails between sessions that regard scheduling. If you have immediate concerns that require my attention, you are welcome to call me, but please understand that I am not on-call, and am generally unavailable during non-work hours (see "Emergencies" below). Otherwise, you can make a note of what happened and we can address it at our next session. Phone calls lasting more than 10 minutes will be billed at a prorated fee based upon your hourly session rate. In the case of emergency, please read below.

Emergencies: I do not provide emergency or crisis response services at my practice. In the event of an emergency, please contact **911** or the **Multnomah County Crisis Line** at **503-988-4888**. If you call me in crisis, I will do my best to respond to you within 24 hours, however I cannot guarantee that I will be available and/or accessing my voicemails. I am generally checking messages during standard business hours, 9am-5pm, M-F. If you email me during an emergency, I will respond to your email with a phone call. If you are unable to reach me during a crisis, please seek out emergency services as mentioned above. In the event of my extended absence (e.g. vacation), I will ensure that clients are notified of my absence, and are provided with crisis resources as necessary.

Grounds for Termination: There may be times, during the course of therapy, that I determine your therapeutic needs are beyond my scope of practice, or fall outside the parameters of our initial therapeutic goals. In this event, I will work with you to facilitate an appropriate referral that better suits your current needs. Additionally, I reserve the right to end the counseling relationship if it is reasonably clear you are no longer benefiting from services. In such situations, appropriate referrals will be made. If you choose to decline the referral, the therapeutic relationship will still be terminated.

Evaluations: I do not provide psychological evaluations, child custody evaluations, evidence for disability determination, forensic evaluations (e.g., collecting information in a legal proceeding) or expert testimony for the court. If you are seeking this type of assistance, please inform your therapist.

Release of Records: I do not routinely release client records. In some circumstances a summary of treatment may be provided. All records requests must be provided in writing, stating the specific information being requested and its intended use. For relational therapy, consent must be obtained from all adult members before any records will be released. Records requests may require up to two weeks to process. Fees will be charged for copying services.

Payments & Insurance Reimbursement: Clients are expected to pay the agreed upon fee at time of session. I understand that Nate's fee for service is subject to change with 30 days minimum written or verbal notice. I do not charge for brief phone calls (less than 10 minutes). Longer telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please note that I am not affiliated with any insurance panels, which means I do not accept insurance. This can be beneficial in several ways. First, I will not be required to assign you a mental health diagnosis as a part of treatment. Additionally, there will not be a fixed limit on the number of sessions available to you. You will also be able to determine your own goals for therapy. If reimbursement for services is an option for you through your insurance company's out-of-network services, I can easily provide you with receipts that will have all of the information you need to file. Please understand that I do not guarantee out-of-network reimbursement. While I am happy to provide you with the necessary paperwork, issues related to reimbursement for claims submitted are strictly between you and your insurance company. In the event your insurance company requests additional documentation, I will do my best to provide the necessary information. In the event an out-of-network submission for reimbursement is denied, you will still be financially responsible for payment for sessions. In other words, I make no guarantee of out-of-network reimbursement. This is for you to determine with your insurance provider.

Cancellation & Re-scheduling: 24-hour notice is required for the cancellation or rescheduling of an appointment. If less than 24-hour notice is given, or if clients "no-show" the appointment, clients will be charged a full session's fee for the missed appointment. If a client reschedules an appointment more than once during a calendar week, they are subject to being charged for that appointment. More than two missed appointments without 24-hour notice may result in the termination of therapy. If you are late to a session, we will still end at the scheduled time. Clients are responsible for rescheduling sessions. Client files will be closed after 60 days of inactivity, unless we have made prior arrangements for a longer break in services.

The Process of Therapy: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward goals requires effort on your part. Psychotherapy requires your active involvement, honesty, and openness in order to change your thoughts, feelings and/or behaviors. I may ask for your feedback and views on your therapy, its progress, and other aspects of therapy and will expect you to respond openly and honestly. Please feel free to bring up any concerns or questions at any time and also remember that you have the right to request changes or to refuse treatment at any time.

Caregiver Permission to Treat a Minor: I give my permission for Nate Wilson-Traisman to provide mental health services to my child. If I am co-parenting and have joint custody, I am in compliance with the custody agreement regarding health care decision making (e.g., as described by the parenting plan). Please indicate legal authority for guardianship (e.g., custodial parent, legal guardian, court appointed guardian): _____

By signing below, I am verifying that I have legal authority to provide consent for therapy.

Name of Child: _____ Date of Birth: _____

Name of parent/guardian: _____

Signed: _____ Date: _____

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Signatures for Basic Information Sheet and Consent for Treatment

My signature below means that I have read this agreement, or have had it read to me, and agree to the above.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of client	Printed name	Date

I, Nate Wilson-Traisman LMFT, have discussed the issues above with the client. My observations of his or her behavior and responses give me no reason, in my professional judgment, to believe that she or he is not fully competent to give informed and willing consent.

_____	_____
Signature of counselor	Date

I assume responsibility for the charges accrued for my sessions at the rate of $_____, as agreed upon. I assume responsibility for canceling sessions with more than 24-hours notice or will pay the fee equivalent to one session.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of client	Printed name	Date