Heather Lokteff, MS., LPC
Licensed Professional Counselor
4800 Meadows Rd, Suite 300, Lake Oswego, OR 97035 * 503-806-2012 * info@heatherlokteff.com

Statement of Understanding and Consent for Treatment

It is important that you are a willing, active participant in your treatment. If you have any questions or concerns about this document or services provided, please ask questions. Feel free to seek other professional opinions and options so that you feel that you are engaged on the best course of action to meet your needs.

HOURS/CONTACT: I am generally available by appointment only, Monday through Thursday, 7:30am-5:30pm. You may call and leave a message at any time and I will return your call as soon as possible. My policy for after-hours coverage is to leave a message and I will return your call the next business day. If you are in need of urgent or emergency services after hours, contact your local social services, crisis line or dial 911.

RISKS/BENEFITS: Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and hopelessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

ETHICS: I am a Licensed Professional Counselor through the state of Oregon and follow the ethical guidelines set out by the Oregon Board of Licensed Professional Counselors/Therapist. In your best interest, I can only be your therapist. This means that I cannot have any other role in your life. In order to protect your confidentiality, I will not acknowledge you outside of the therapeutic setting. Professional counselors also cannot accept gifts from clients.

TERMINATION OF SERVICES: Any client has a right to refuse or discontinue treatment at anytime without penalty. If needed a referral will be provided. If you disengage from our therapeutic relationship, I will close your file after 30 days of no contact. Counseling services are ended under any of the following events: a mutual agreement between counselor and client(s), client's request, necessity of making a referral as appropriate for best client care, threats or harassment made by client to counselor where counselor feels unsafe and unable to be unbiased in delivery or treatment in best interest of client, if a client has more than two unpaid cancellations, if client has not been seen for more than 30 days and has not contacted counselor.

COURT/RECORDS: As part of my professional practice, I do not testify in court about family matters including custody issues related to minors. I am not trained as a court expert witness and request you let me know if there are legal issues involved. I would refer you to your legal team that can identify the best plan of action and select a professional trained as an expert witness to support your situation. If a client requests records, 15 days are required to prepare. I provide a summative letter of clinical services provided or summative notes for each session upon discussion with client. The fee for this service is $125 an hour, which may be billed in 15-minute increments.

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MINORS/DIVORCED PARENTS: If you are under 18 years of age and are not emancipated, please be aware your parents have the right to know information on your treatment including treatment goals, diagnoses, and treatment methods. I ask parents to respect their minor's confidentiality and trust I will inform you of any safety concerns that need to be brought to your attention. Also, my confidentiality extends to your child alone; a parent must know that what is shared by them can be shared with the other parent and his/her child.

I will need consent from the custodial parent who has the medical decision-making authority. In some joint-custody arrangements, this means I need consent from both parents. At times, I may request a copy of the divorce to verify custody arrangements. In situations where I am providing services to a child of parents who are separated, I may recommend that both parents participate in treatment.

My role as your child's therapist is a support to your child; I am not a custody evaluator and will not be involved in determining parenting time and/or custody arrangements. By signing this consent parents agree to not try to use therapeutic records or testimony to influence custody and further agree that parents' lawyers will not subpoena therapist or therapist's records for testimony. You are expected not to use the therapeutic process for your own legal purposes or against the other parent in court. However, if a judge issues this therapist a subpoena, therapist will comply and follow through with the action that is requested of therapist by the judge.

The biggest predictor for positive outcomes with divorcing parents is parental collaboration, positive co-parenting, and the ability for the child to engage in a positive relationship with each parent. By signing this informed consent, you are agreeing to put your child's best interest above all other matters.

ELECTRONIC COMMUNICATION: Email and text messages are useful methods of correspondence for clients. Transmitting confidential information by email or text messages can create a number of risks that clients need to be aware of if they choose this method of correspondence. Please be aware that phone, texting, and email communication can be intercepted in transmission or misdirected. Emails sent to/from your employer's computer may be accessed by your employer.

I will make efforts to respond to your email promptly but cannot guarantee that any particular email message will be read and responded to within any certain time frame. Because the response cannot be guaranteed please **do not use email or text messaging in a medical emergency**. Should you choose to communicate by email or text messaging, please understand this is for appointment changes/clarification and sharing information. **Therapy will not be conducted through email.** Any pertinent correspondence will be printed and made part of your medical record.

As a general rule, I do not have contact with clients outside of the office that is unrelated to mental health treatment. This rule applies to various internet messaging sites, social networking sites and general emails unrelated to our professional relationship. Please understand that any contacts or requests for contacts will not be confirmed or acknowledged to protect your privacy as well as to eliminate a dual relationship.

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By signing this document you are acknowledge you understand the risks associated with utilizing any electronic methods of communication and agree to do so at my own risk

FEES: I provide services at $125.00 per 45-50-minute session, and the initial intake session is $150. These payments represent a charge that is reasonable and customary for my location. Payment and insurance copays due in full by cash, check or credit card at the end of each session. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred. Per request, I charge the same rate for report writing and community-based meetings (school, court, etc). If using health insurance, you are responsible for any portion of the rate they do not cover. Also, health insurance require a mental health disorder diagnosis on the claims.

CANCELLATION POLICY: Please call **24 hours in advance** to change or cancel an appointment to allow that time for another person. You are able to leave a message 24 hours a day. If you do not show for an appointment and do not call to cancel within 24 hours of the session, **you will be billed the $125** for the session to your credit card. Please know that **health insurances do not cover cancellations**. This is a customary charge in my profession. By making an appointment you are setting aside this time, which cannot be filled without proper notice. Thank you for respecting my time and following this policy.

PAYMENT POLICY AND AGREEMENT: In the event that my account has not been paid within 60 days, I authorize Heather Lokteff, MS, LPC to charge the following account for services according to the financial policies and payment agreement above. At which time, account will be charged any unpaid balance. You can also opt to use this card on file for co-pays per session.

Type of card: Visa MasterCard American Express Debit HSA

Account Number:_____ Expiration Date:_____
Security Code:_____ Billing Zip Code:_____
Card Holder Name:_____Signature:_____

CONFIDENTIALITY: Please understand that information obtained from you is confidential under Oregon law. Information may not be shared with anyone without your permission except in the following circumstances:

- When a court order is received.
- When there is reasonable cause to believe that you will hurt yourself or someone else.
- When there is reasonable suspicion to believe that abuse and/or neglect of a child, an elderly person, disabled person or any animal is occurring or has occurred.
- Information necessary for billing purposes, justification of treatment, and resolution of a complaint.
- Providing general information for therapist case consultation or supervision.

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Your initial beside each of the following indicates your understanding and consent for treatment:

_____ I understand that I may withdraw consent for treatment at any time.
_____ I understand and have reviewed statement of fees and cancellation policy.
_____ I understand and consent to the use of Electronic Communications policy.
_____ I understand confidentiality and its limitations.
_____ I have received a professional disclosure statement (available on website/office)
_____ I have received a copy of HIPAA's Notice of Privacy Practices (available on website office)

Your signature indicates that you understand this "Statement of Understanding and Consent for Treatment" and agree to the above. I hereby give Heather Lokteff, MS, LPC consent to provide my treatment.

_____	_____	_____
Print Name	Client Signature	Date
_____	_____	_____
Print Name	Client Signature	Date
_____	_____	
Clinician Signature	Date	

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CLIENT INFORMATION/HEALTH HISTORY

Name: _____Date:_____
Address: _____
_____Phone: _____
Email: _____
Preferred method to contact you and leave message: _____
Birthdate: _____ SSN: _____
Marital Status:__single __married __widowed __divorced__separated __living as married
Children: (Age/Sex)_____
Employment Status:__working__unemployed__retired__disability Employer:_____
Emergency Contact Name: _____
Relationship: _____Phone: _____

Health History

Adverse Drug Reactions/Allergies: _____
Primary Care Physician: _____Phone: _____Height: _____Weight: _____
Describe current concerns about your physical health: _____
_____
Past illnesses and treatment: _____
Past medical procedures or surgeries? _____
History of accidents/outcome: _____
Past/current menstrual, prenatal, pregnancy, labor/delivery, postnatal issues:
_____
Physical impairment/limitations/disability:_____
Recent hospitalizations in past 2 years:_____
List current medications including over the counter drugs, vitamins, herbal supplements:
_____
_____
_____
Are you currently experiencing any pain? ____Where is pain located? _____
Are you receiving treatment for pain? ____ Who is your provider? _____

RISK ASSESSMENT

Suicidal thoughts □Past □Current □Thoughts □Plan □Intent □Attempts Method_____
Self harm □Past □Current □Thoughts □Plan □Intent Method_____
Aggression □Past □Current □Thoughts □Plan □Intent Method_____
Ever lived in □Jail □Detention □Prison □Nursing Facility □Shelter □Homeless

SUBSTANCE ABUSE AND ADDICTION ASSESSMENT

Do you think you have a problem with □drugs or □alcohol? Do others believe you have a problem with □drugs or □alcohol?
Do you have a problem with another type of addiction such as □gambling, □shopping, □sex, □food, □money or □work?
Do you have these concerns with addiction or substance abuse: □health problems, □legal problems, □increased tolerance to substances, □family history of addiction, □black-outs or

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memory loss, □difficulties in family, friends, work or school, □tried to cut down or quit, □received help for addiction?

Have you had counseling previously? ___ Have you ever received other mental health treatment other than counseling, such as inpatient, hospitalization, etc? _____
Have you ever had any legal difficulties? _____

Please check if you have difficulty or history of any of the following:

Abnormal Bleeding		Fainting Spells		Long term memory		Restlessness	
Addiction		Fear leaving home		Mania		Seizures	
Aggression		Financial concerns		Medication issues		Self harm	
Anemia		Gastro-intestinal		Mood swings		Sexual abuse	
Anger		Hallucinations		Nervousness		Short term memory	
Anxiety		Headaches		Nightmares		Skin Problems	
Appetite problems		Head Injury		Night sweats		Sleep disturbances	
Asthma/Respiratory		Heart/Circulatory		Obsessions		Social anxiety	
Cancer/Tumors		Hypersomnia		Pace Maker		Stress	
Compulsions		Hypertension		Panic		TB	
Concentration		Infections/HEP		Paranoia		Thoughts of death	
Confusion		Insomnia		Personality Disorder		Trauma	
Depression		Intrusive thoughts		Phobias		Trauma flashbacks	
Diabetes		Irritability		Physical abuse		Veteran/Military	
Dietary changes		Irritable Bowel		Pneumonia		Visual difficulties	
Disordered eating		Joint/Muscle		Racing thoughts		Weight gain/loss	
Domestic Violence		Kidney Disease		Relationships		Worry	
Emotional abuse		Learning/Focus		Repeat behaviors		Worthlessness	
Employment		Legal difficulties		Repeat thoughts		Other:	

Please write anything else you think I should know on the back of this form.