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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To be filled out by parent/guardian

CHILD'S NAME: _____ DOB _____ AGE_____ DATE_____

Name of Person filling out this form _____
Relationship to Child _____
Address: _____
_____
Phone: _____ Email:_____

PERSONAL HISTORY:

-Who is the child raised being raised by? (list parents, stepparents, guardians) _____
-List child's siblings and ages: _____
-How is the relationship between child and mother? _____
-How is the relationship between child and father? _____
-How does child typically get disciplined? _____
-What does child enjoy doing with family? _____
-What does child enjoy doing with friends? _____
-What does child enjoy doing alone? _____
-Please check any of the following that describes child's current and past atmosphere:
-Put (P) for past and (C) for Current

Alcholism		Competitive		Moving a lot		Stable	
Affectionate		Democratic		Neglectful		Supportive	
Angry		Fighting		Physical Aubse		Trusting	
Blaming		Frightening		Physical Illness		Unkind Words	
Close		Fun		Poverty			
Cold		Mental Illness		Sexual Abuse			

-Please describe any known or suspected abuse on the back of this page
-Child's school and grade: _____
-How does child do in school? _____
-Has child ever been in counseling before? (Yes) (No)
-Is child currently attending a church/temple? (Yes) (No)
Where? _____ Frequency: _____

MEDICAL HISTORY:

Describe any illnesses or injuries requiring hospitalization or emergency treatment in the last three years?
_____
_____
Describe child's overall health at this time: _____
List any medications child may be taking at this time and the reason for taking them: _____
_____
Treating Physician's Name and Phone #: _____
Describe any developmental delays or problems in pregnancy: _____
_____

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POSSIBLE CONCERNS FOR DISCUSSION IN COUNSELING:

Children: Please check those of concern

Aggression		Fighting		School Performance	
Alcohol/Drug Use		Friendships		Self-Harm	
Allergies		Grief		Sexual Abuse	
Anger		Health problems		Shyness	
Anxiety		Hyperactivity		Sleep	
Appetite/Eating		Impulsiveness		Social Anxiety	
Arguing		Irritability		Stealing	
Attentiveness		Jealousy		Stress	
Bedwetting		Low Self-Esteem		Suicidal Thoughts	
Bully victim		Lying		Suicide Attempts	
Complaining		Mood swings		Tantrums	
Concentration		Nightmares		Withdrawn	
Depression		Panic		Witnessed Abuse	
Divorce/Separation		Physical Abuse		Worry	
Disobedience		Running Away			
Fears		Sadness			

How is your child socially? _____
_____

From whom does child currently receive support and encouragement? _____
_____

What strengths does child possess? _____
_____

If counseling were successful, what would be noticeably different? _____
_____

Are there any hesitations, fears, or concerns about counseling? _____
_____

Please list your main counseling goals: _____
_____
_____
_____

On the back of this form, please make a general time-line of the major events in this child's life. Include divorces, moves, deaths, living with substance abuse, abuse, adoptions, etc.