Rocky Garrison, PhD, CBSM, Clinical Psychologist
12 SE 14th Ave., Suite 104, Portland, OR 97214
phone: 503.317.4521 fax: 503.512.6112
e-mail: rockygarrison@gmail.com
www.rockygarrison.com

TREATMENT CONTRACT

I. RIGHTS

Confidentiality: You may review my "**Notice of Privacy Practices**" for additional information about the uses and disclosures of information. The following are legal exceptions to your legal right to confidentiality. I would inform you of any time when I think I will have to put one of these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or a vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police. I would explore all other options with you before I took this step.

4. If we have some individual sessions as a part of couples or family therapy, what is said in those individual sessions can and probably will be discussed in the following couples of family sessions. ***Do not tell me anything you wish kept secret from other family members who are in therapy with me.*** I will, however, maintain the confidentiality of information told to me in individual sessions when consulting with parents or other persons.

5. I may have to release your records when ordered to do so by court subpoena. I will discuss this with you beforehand.

6. I may have to release clinical information regarding you to insurance carriers as required for payment or review of your claim.

Other Rights:

1. You have the right to know **potential risks and benefits** of the therapy you are receiving. 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 which 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.
2. **Treatment works best if you are knowledgeable about your problems and diagnosis.** You have the right to ask me questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing as well as my diagnosis and understanding of you and your problems.
3. **Treatment works best if we work as a team.** We will work together to establish the goals and duration of therapy, and you have the right to discuss and change these at any time. Most insurance plans will provide payment for services which are determined to be medically necessary, and I will inform you about the medical necessity of your treatment. You have the right to participate in the decision regarding the conclusion of our work together.
4. **Emergencies.** I am available by phone for emergency contact by calling 503-317-4521. I will return the phone call as soon as possible. When I am unavailable I will have substitute coverage available through the same phone number.
5. If I am not able to help you, you have the right to a referral to another therapist who can meet your needs.

(continued over)

II. RESPONSIBILITIES

Attendance:

1. You are responsible for coming to your sessions at your scheduled time. If you are unable to keep an appointment, please notify me immediately by phoning 503-317-4521. If an appointment is missed, you will be billed for the session. I cannot bill these sessions to your insurance.
2. You are responsible for telling me when you wish to conclude treatment.

Payment Method: The client or their guardian is considered responsible for payment of professional fees. If we have agreed to bill a third party and that third party fails to make payments, I will notify you in writing and arrange a payment schedule.

My copayment/fee is **$**_____. Select one:

1. Payment of all nonallowable, co-payment and deductible charges will be made at the time of service.
2. Payment will be made upon receipt of a monthly statement issued on the first of each month.
3. Payments of **$**_____ per month will be made upon receipt of a monthly statement issued on the first of each month until all charges are paid in full.

Defaulted accounts may be sent to collection, and if an attorney is hired to collect the outstanding balance and occurring charges, client agrees to pay all costs and a reasonable attorney's fee incurred.

Insurance and Third Party Payments: If you want me to bill your insurance carrier, I will bill on a monthly basis, and you are responsible for payment of all nonallowable, co-payment and deductible charges for medically necessary treatment. Some insurance plans require pre-authorization of services.

Responsibility: By signing this agreement the client and the responsible person agree that they have read it carefully, understand the contents, and have been offered a copy of it. Check the following if you agree:

- ❑ I have reviewed Dr. Garrison's "**Notice of Privacy Practices,**" and have been provided with a copy of this Notice if I requested one.
- ❑ In order to coordinate the care I receive, I **authorize** Dr. Garrison to disclose my health and clinical information to:
  - ❑ my primary care physician
  - ❑
  - ❑

_____ _____

client therapist

date:

_____ _____

guardian guardian

[one] or [both] guardian signatures are required