HAWTHORNE HEALING CENTER
Transformational Counseling & Wellness

COURTNEY ARBAN - M.S. Clinical Mental Health Counseling

& Licensed Professional Counselor Associate

INFORMED CONSENT

Your counselor holds a Master's Graduate Degree in Clinical Mental Health Counseling, is a Licensed Professional Counselor Associate, and adheres to a code of Ethics governed by The American Counseling Association. These ethics exist to protect you as a client as well as your therapist. You can read the ACA code of ethics in its entirety at www.oregon.gov/OBLPCT.

What you say during counseling is confidential and will not be disclosed to anyone outside of the supervision process (see above) without your permission, but there are some exceptions to confidentiality. Counselors are required by law, and by their professional ethics, to break confidentiality (a) if a counselor believes that someone is seriously considering and likely to attempt suicide; (b) if a counselor believes that someone intends to assault another person; (c) if a counselor believes someone is engaging or intends to engage in behavior which will expose another person to a potentially life-threatening communicable disease; (d) if a counselor suspects abuse, neglect, or exploitation of a minor or an incapacitated adult; (e) if a counselor believes that someone's mental condition leaves the person gravely disabled; (f) if required by law to disclose information; (g) if records of clients need to be read by authorized auditors or researchers for approved purposes.

MEDIA DISCLOSURE: Please read and initial the following statements:

1. I understand that due to the nature of electronic communication, any e-mails, texts, phone calls and voicemails between my counselor and me, though exchanged only between us, are not guaranteed to be strictly confidential. I accept this and give my consent to communicate via electronic means. _____

2. I understand that due to the lack of guaranteed confidentiality in electronic communication, my counselor will only correspond regarding scheduling and payment logistics, but not about session content. _____

3. I understand that while I may be a part of various social media groups (ie; Facebook, Pinterest), my counselor will maintain professional boundaries with me and will not be linked to me on any social media sites. _____

UNDERSTANDINGS: Please read and initial the following statements:

I have read and understand the information on this page and on the attached PDS provided. I also understand the limits of confidentiality as described above. If there is anything I do not understand, I will seek clarification from my counselor before I sign. _____

By signing this form I also recognize that I am agreeing to enter into a therapy relationship and will be receiving clinical counseling for treatment of my presented issues. _____

_____ _____ _____ _____

Client Date Counselor Date

_____ _____

Emergency Contact (Printed Name) Phone Number

If the client is a minor (under the age of 18) This portion to be signed by PARENT/GUARDIAN:

I affirm that I am the legal parent or guardian of (client's name): _____

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I understand the above information, and I do grant permission for my child to participate in individual and or group counseling. I understand that what my child discusses with his/her counselor will be confidential between only them, unless the above "mandatory reporting" issues arise.

I understand that my child (the client) will be building a safe and trusting relationship with the therapist for his/her own health and development and that I will not be discussing his/her counseling sessions with **COURTNEY ARBAN** (the therapist/ LPC Associate).

Parent/Guardian's Full Legal Name (s): _____

Signature of parent/guardian: _____ Date: _____

Witness signature: _____ Date: _____

For the client (minor who is under the age of 18 years) to sign:

I, (client's Name) _____, understand that what I say to my counselor will be held in strict confidentiality, unless any of the mandatory reporting issues regarding my safety outlined above arise.

Because I am under my parent's guardianship I understand that they may be involved in the logistics of my counseling session. I give my counselor, **COURTNEY ARBAN** full permission to be in contact with my parents regarding the following issues, if needed:

- Scheduling of appointments; including day, time and duration. _____ (initial)
- Billing and Payment matters. _____ (initial)
- Professional referral information, ie; names of other healthcare professionals, if needed. _____ (initial)

Client (Minor) Signature_____ Date: _____

Counselor's Signature _____ Date: _____

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Notice of HIPPA Privacy practices of **COURTNEY ARBAN**, LPC Associate in the state of Oregon: This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED: The uses and disclosures of your health information fall into the categories below. Your health information will not be used or disclosed for any other purposes unless you give your written authorization to do so. You may revoke an authorization, at any time, in writing, except to the extent that we may have taken action in reliance on the use or disclosure indicated in the authorization.

A. Uses and Disclosures for Payment.

- We may use and disclose your health information for payment activities. For example, in order to obtain payment, we may give your general health plan information about your care.

B. Uses and Disclosures of Your Health Information That May Be Made Unless You Object.

- Appointment Reminders. We may use and disclose health information to contact you as a reminder that you have an appointment.
- Treatment Alternatives. We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We will obtain your authorization first, if we receive direct or indirect payment from a third party for the communication.
- Individuals Involved In Your Care. We may release health information to a person who is involved in your medical care or helps pay for your care unless you restrict such disclosure.

C. Uses and Disclosures We May Make Without Your Authorization.

- Required By Law. We will disclose your health information as required by law.
- Health or Safety. We may use and disclose your health information to a person who is able to prevent or lessen a serious threat to the health and safety of you or the public.
- Business Associates. We may disclose your health information to our business associates that perform functions or services on our behalf.
- Military and Veterans. If you are a member of the armed forces, we may release health information as required by military command authorities.
- Lawsuits and Disputes. We may disclose your health information to answer a court or administrative order, subpoena, discovery request, or other process as permitted by law.

D. Uses and Disclosures That Require Your Authorization

- Psychotherapy Notes: Most uses and disclosures of psychotherapy notes by our mental health counselor that are kept apart from the rest of your record require your authorization.
- Other Uses and Disclosures: Uses and disclosures other than those described in this notice will only be made with our written authorization.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

- Right to Inspect and Copy. You have the right to inspect and copy your health information for a fee. We may deny inspection and copying in limited circumstances.
- Right to Amend. You may ask, in writing, for us to amend your healthcare information. We may deny your request for an amendment in certain circumstances.
- Right to an Accounting of Disclosures. You have the right to request, in writing, an accounting of our disclosures of your health information.
- Right to Request Restrictions. You have the right to request, in writing, a restriction of our uses or disclosure of our health information for treatment, payment or health care operations. We are not required to agree to such restriction unless the disclosure is to a health plan for payment or health care operations and pertains solely to an item or service for which you have paid out-of-pocket in full.
- Right to Request Confidential Communications. You have the right to request, in writing, that we communicate with you about health matters in a certain way to maintain confidentiality. We will agree to reasonable communication requests.
- Right to Receive Notification of a Breach. You have the right to be notified if we discover a breach of your unsecured health information.
- Right to a Paper Copy of This Notice. At any time, you have the right to a paper copy of this notice, even if you have agreed to receive this notice electronically.

I have read and understand this Notice: Name:_ _____

Signature: _____ Date: _____

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FINANCIAL & BILLING DISCLOSURE STATEMENT

COURTNEY ARBAN, LPC Associate

Please read carefully, initial each portion and sign/date this agreement:

1. **PROCESSING FEES:** Payment for services may be in the form of cash, check, debit, Visa, MasterCard, Discovery, or American Express. For all credit and debit card transactions, an additional 3.5% fee will be charged. For returned checks, a $35 processing fee will be assessed. By initialing this portion you acknowledge and accept any and all future assessment of these fees:

Initials:_____

2. **CANCELATION POLICY:** For all commercial insurance holders or "out-of-pocket" customers, **COURTNEY ARBAN** and Hawthorne Healing Center, LLC have a 24 hour Notification Policy for client cancellations/no-shows. Please notify us if any appointment needs to be cancelled or missed, a MINIMUM of 24 hours prior to the scheduled appointment time. Failure to offer 24 hour notice will result in the full fee still charged. By initialing this portion you are agreeing to pay your full fee(s) when canceling/no-showing within a 24 hour period.

***For all **OHP** (Jackson Care Connect, Oregon Health Share, Care Oregon) customers, **COURTNEY ARBAN** and Hawthorne Healing Center, LLC have a "2 strikes" policy for any failure to give a full 24 hour notification of cancellation/no-show. Within a 12 month period, you may miss one session without giving full 24 hour notification. Once you miss a second session without giving full 24 hour notice, you will be removed from our schedule and will need to seek treatment elsewhere.

Initials:_____

3. ADDITIONAL SERVICES: Some services, such as coordination with other agencies, court orders, family services, etc. require your therapist's time and resources. In the event that you require additional coordinated services and your therapist requires compensation for these services, this responsibility will fall to you (the client) and/or any other providers/persons/agencies making the request. By initialing this portion you acknowledge responsibility for additional services that do not fall under the scope of a 55 minute session.

Initials:_____

4. FEES FOR SERVICES: **INSURANCE**

55 minute Individual session: $175 billed to insurance

Depending on your insurance company and policy, you may be eligible for billing for these fees.
Please check with your counselor to see if your Insurance is currently accepted.

If you choose to use your insurance, your counselor will help by submitting your claim for you and will bill the MAXIMUM amount allowable (see rates above). In the event that your claim is rejected, for any reason, you will be responsible for the full amount remaining on your bill. By initialing this portion you accept responsibility and agree to pay for ANY AMOUNT NOT COVERED by your insurance (Including Co-pays).

Initials:_____

FINANCIAL HARDSHIP: If you do not have insurance or choose not to use it, you may pay for sessions on the date of service: 55 minute individual session: $135. By initialing this portion, you are agreeing to pay these rates "out-of-pocket" and that no invoices for services will be submitted/nor any insurance reimbursement pursued.

Initials:_____

I UNDERSTAND AND AGREE TO ALL FINANCIAL DISCLOSURES WHICH I HAVE INITIALED ABOVE.
I UNDERSTAND THAT EVEN THOUGH I MAY BE SUBMITTING INSURANCE CLAIMS I AM ULTIMATELY RESPONSIBLE FOR ANY FEES INCURRED AND AGREE TO PAY HAWTHORNE HEALING CENTER, LLC FOR ALL THERAPY SERVICES, INCLUDING MISSED APPOINTMENTS OR LATE CANCELS:

PRINTED NAME: _____

SIGNATURE:_____

DATE:_____

COUNSELOR'S SIGNATURE: _____

DATE:_____

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PROFESSIONAL DISCLOSURE STATEMENT

COURTNEY ARBAN, **LPC Associate**
971. 398. 8376
21 Hawthorne St., Medford, OR 97504

APPROACH TO THERAPY: In honoring the collaborative nature of counseling, I intend to be present and compassionately walk alongside you as you deepen your understanding of self. I believe that we each possess the tools necessary to achieve our goals. Yet, we may benefit from the support of a professional who can guide us in discovering and utilizing them towards self-mastery.

I help individuals identify and challenge unhelpful thought and behavioral patterns that create tension in their lives. By encouraging an exploration of existing strengths, clients can further develop resiliency and foster long-term, healthy change. I believe, when the therapeutic relationship is strong, identifying the ways a client is living inconsistently with their values can be a shared practice. I intend to confront gently and with empathy. I wish for you to explore parts of yourself that, when healed, can increase the potential for a truly peaceful and joyous life. Sometimes this curiosity will open wounds you have buried deep inside. I can't guarantee your success in treatment, as your dedication to facilitating awareness and change is at the forefront of how much you will benefit. However, I will do everything I can to ensure you are provided with the skills necessary to process and evolve.

I am adaptive in tailoring therapeutic interventions to your needs and strive to provide an inclusive, safe space. I feel confident and comfortable working with clients from various backgrounds, including those who identify with LGBTQ+, kink-lifestyle, and polyamorous/unique relationship arrangements. All are welcome. While I do utilize evidence-based practices, I am creative and open to incorporating various techniques, including ones that fit within one's cultural or spiritual framework.

EDUCATION & TRAINING: I have a Master of Science Degree in Clinical Mental Health Counseling from Nova Southeastern University. I strongly believe in approaching counseling through a lens of trauma-informed and multicultural care and have close to ten years of experience in case management. I have been trained to work with a variety of mental health disorders but more extensively with depression, anxiety, PTSD, OCD, suicidality, substance abuse, and survivors and perpetrators of domestic violence. My theoretical orientation is integrative of Existentialism, Humanism, Dialectical Behavioral Therapy, and Cognitive Behavioral Therapy. I also pull from Systems Theory, Psychoanalytic Theory, and Attachment Theory and utilize Mindfulness-based interventions.

As a **Licensee Associate** of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. I am required to, and attend, monthly supervision with Maria Connolly, LPC. I am happy to answer any questions you may have about my credentials or status as a counselor.

FEES: 55-minute individual session: $135 ("Out-of-Pocket" rates)
INSURANCE BILLED: OHP (Jackson Care Connect, Oregon Health Share, Care Oregon)

A 24-hour Cancelation Policy will be strictly abided by. If the client cancels less than 24 hours before their scheduled time, they will still pay their full hourly rate for the missed session (see exception to OHP clients).

ALL FEES ARE DUE ON OR BEFORE DATE OF SERVICE. Future sessions cannot be booked if prior fees are still owed.

YOUR RIGHTS AS A CLIENT:

- To expect that your counselor has met the qualifications and training required by state law.
- To examine public records maintained by the board and to have the board confirm credentials of a Registered Intern
- To obtain a copy of the code of ethics and to report any complaints to the board
- To be informed of the cost of professional services before receiving the services
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, with the following exceptions; 1) Reporting suspected child abuse, 2) Reporting imminent danger to client or others, 3) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies, 4) providing information concerning intern case consultation or supervision, 5) Defending claims brought by client against intern.
- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status or sexual orientation.

You may contact the Board of Licensed Professional Counselors and Therapists at 3218 Pringle Rd. SE #250 Salem, OR 97302-6312 Telephone: (503) 378-5499, E-mail: lpct.board@state.or.us website: www.oregon.gov/OBLPCT

*For additional information on this therapist, please see the board's website: www.oregon.gov/OBLPC

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

BENEFITS & RISKS OF TELEPSYCHOLOGY:
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care when we are being asked to practice social distancing. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- RISKS TO CONFIDENTIALITY: Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. As your psychotherapist, I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- ISSUES RELATED TO TECHNOLOGY: There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- CRISIS MANAGEMENT & INTERVENTION: Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- EFFICACY: Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

ELECTRONIC COMMUNICATIONS
We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.
Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone or text. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

CONFIDENTIALITY
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

EMERGENCIES & TECHNOLOGY
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, Jackson County Crisis Line (541-774-8201), or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

FEES
The same fee rates will apply for telepsychology as apply for in-person psychotherapy.

RECORDS
The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

INFORMED CONSENT
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____
Client Date

_____ _____
Therapist/ Counselor Date