Margaret H. Anderson, Psy.D.
1210 Dry Hollow Road #2
The Dalles, OR 97058
541-298-2298

INFORMED CONSENT FOR TREATMENT AND EVALUATION

You have certain rights when consulting with a psychologist for treatment or evaluation:

1. You have the right to be informed regarding the terms under which treatment or evaluation will be provided. Policies related to charges, billing third party payors, appointments, emergencies, and coverage for when I am unavailable, and other matters are provided in my policy statement and can be discussed further if you have any questions.

2. You have the right to choose the best treatment and provider. There are many different approaches to working with human issues and a variety of providers who offer therapy and evaluation services. It is your right and responsibility to choose the treatment and provider that best matches your needs. You have the right to an explanation of treatment I provide including the risks involved and the side-effects, if any. If you believe you are not receiving the treatment you require, then raise this concern with me and I will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.

3. You have the right to know the qualifications and training of your provider. Please ask me any questions you may have about my training and experience. You can also refer to the credentials section of my policy statement.

4. You have the right to refuse treatment or stop treatment or evaluations at any time and for any reason. In the case where a minor is the client, then the parent(s) or legal guardian has the right to refuse or stop treatment for the minor. I also have the right to refuse or terminate treatment, in which case you will be provided with alternatives. It is my hope that if you have concerns regarding your treatment or wish to discontinue you will discuss this with me.

5. You have the right to confidentiality. This means that what you tell me and what is contained in your clinical file will not be repeated or released to anyone else without your written permission. You have the right to see and have access to your own file. You have the right to discuss your own therapy or evaluation with anyone. Because we live in a relatively small community, it is not unlikely that I will see clients in public. If this occurs, it is my policy not to initiate contact. Instead, I leave it up to my clients to decide whether they want to talk to me as an extra protection of their confidentiality. Confidentiality has exceptions when information may be shared without your permission:

- if I received first-hand information about harm done to a child or elder or disabled person,
- if you tell me or I come to believe that you or someone else will be harmed,
- if you commit a crime against me,
- if your or someone else's welfare appears in imminent danger,
- if I am subpoenaed to testify in court.

Attached is a Notice of Privacy Practices. This notice explains the Health Information Portability and Accountability Act (HIPAA), a federal law that provides privacy protections with regard to the use and

disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations.

6. For minors 14-17 years old. Psychologists may provide treatment to adolescents 14 and older without parental consent. Oregon law requires me to have your parent(s) involved before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. I do not have to involve your parents if you have been sexually abused by your parents, or if you are emancipated. By signing this form, you:

- authorize me to contact your parent(s) and give them a summary of your treatment by the third session,
- authorize me to use my best judgment about when to inform your parent(s) about important issues related to your treatment,
- authorize me to release your records to your parent(s) if they request this.

By signing below, I authorize Margaret H. Anderson, Psy.D. to provide therapy and/or evaluation services to _____ (client name). I understand that I am also assuming ultimate financial responsibility for the cost of the treatment. I also agree that I have had the opportunity to discuss the potential benefits and risks of the therapy to be done by Dr. Anderson. This consent can be revoked at any time in writing. Your signature below also serves as an acknowledgment that you have received the HIPAA notice described above.

Signature of client_____ Date:_____

Signature of parent/legal guardian_____ Date:_____

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