Welcome to my practice. Please read this paperwork carefully as it contains information concerning my office policies and procedures as well as your rights as a client. If you have further questions after reading this, or you have individual concerns not covered here, please feel free to ask me about them at any time. I am in the independent practice of psychotherapy. Although I share office space with other practitioners, we are not in partnership together, and we do not supervise each other's work.

## Professional Credentials

I am a Licensed Clinical Social Worker with a Masters Degree in Social Work from the University of Michigan. I have been in practice since 1989, and work with children, adolescents, and adults as well as with families, couples and partners.

## Treatment

The initial appointment is 60 minutes in length and 55-60 minutes thereafter. During the initial appointment I will gather thorough history about you and your family as well as learn about the concerns that are bringing you to therapy. In the next session I will work with you in determining your treatment goals.

It is important that you understand your commitment to the therapeutic process. While I use methods that research and experience have shown to be effective with most clients, therapy requires active, regular participation on your part. External factors such as events in your or your child's life, or irregular attendance can interfere with the therapeutic progress. Painful feelings can come up during times of exploration, reflection and growth and at times things may "feel worse before they feel better". We will work together to help you manage these feelings. Please discuss with me any concerns that you have regarding the therapeutic process.

## Confidentiality

What we discuss in our sessions is confidential and protected by Federal and State confidentiality laws and by my professional code of ethics. **Except in cases mentioned below**, information will not be discussed or released to anyone without your written request or consent. **Exceptions include:**

1) situations where child or elder abuse is suspected;
2) situations or threats of potential harm to self or others;
3) instances when a judge subpoenas records or when I am subpoenaed to testify in court;
4) instances when a therapist is defending against a lawsuit or complaint;
5) instances when a non-custodial parent requests information; and,
6) when I suspect your child's welfare appears to be in imminent danger.

Additionally, I may report to parents/guardians high risk behaviors including but not limited to: sexual misconduct, alcohol/drug abuse, and self-injurious behaviors.

I believe that collaborating with other medical providers, family members, school personnel etc. can be an important part of treatment. You may elect to sign a release of information so that I may discuss or consult with other providers in your life.

**Parents of minors**: My clients who are under 14 years of age who are not emancipated should be aware that the law allows parents (both custodial and non custodial) to examine their child's treatment records. Non-custodial parents are only entitled to records and information pertaining to their child and not to records or information about the custodial parent or other individuals who may have participated in the treatment. Parents who do not have custody or the legal right to consent to medical treatment for their child will need written permission from the custodial parent prior to our initial appointment. At times I may ask for a copy of the divorce decree to verify custody arrangements.

In situations where I am providing services to a child of separated or divorced parents, I may recommend that both parents participate in the treatment.

Fees and Insurance

My fee is $275.00 for the initial appointment and $205.00 for appointments thereafter.

I work with most insurance companies and am on several managed health care and employee assistance plans. You must call Pear Business Services, LLC and give your insurance information **prior to our initial appointment**. They can be reached at 1-888-421-0051. My billing service will call your insurance company to verify benefits. If my services are covered then my billing service will follow through with billing and collecting from your insurance company. I am obligated by contract with your insurance company to collect all co-pays, coinsurance payments or deductibles not covered in your plan. It is important that you understand that if you chose to use insurance many companies will only pay for "medically necessary" services and they will require a mental health diagnosis be given. They may also require pertinent clinical information in order to authorize services and payment.

**I highly recommend** that you also check your benefits and be familiar with your coverage, limits, deductibles and co-pays. Although my billing service and I will do everything we can to collect payment from your insurance company, **you are ultimately responsible** for payment for any services that have been provided to you or your child.

If you do not have any mental health insurance or you chose not to use your mental health coverage, you will be required to pay for the full session at the time of the service unless we have agreed to do otherwise.

**It is your responsibility to pay any payments prior to every session**. Please come with cash or a check already made out to **Linda Heins, LCSW, LLC**. Credit cards may also be used as a form of payment. If at some point in our work together you experience financial difficulties please let me know so we can discuss my financial hardship policies and create a payment plan. In circumstances where balances remain unpaid you will receive notice that collections action may be taken.

Cancellation Policy

Missed appointments or cancellations **with less than 24 hour notice** are subject to my full fee of $205. Because I understand that situations arise, I allow for one missed or late canceled appointment with no charge. **All** other missed appointments/late cancellations will be billed at my full fee. This fee must be paid prior to rescheduling our next appointment. Please note that insurance companies **cannot** be billed for missed or late canceled appointments.

If attendance to appointments becomes counterproductive to treatment goals, therapy may be terminated.

Court Testimony

If you request or subpoena me to testify in court, I will charge you for my time. This includes time reviewing the records, consulting with attorneys, traveling to and from court, waiting and testifying at court, as well as any hours you have requested I set aside to attend court even in the event that court gets postponed.

It is important that you know I do not wish to be party to any legal proceedings against current or former clients, or their parents. My goal is to support my clients to achieve therapy goals – not to address legal issues that require an adversarial approach. Clients entering treatment are **agreeing to not involve me in legal/court proceedings** or attempt to obtain records of treatment for legal/court proceedings when marital or family therapy has been unsuccessful at resolving disputes. This prevents the misuse of your treatment for legal objectives.

If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your involvement in these proceedings might affect our work together. Also, entering into treatment for therapy is not the same as a psychological evaluation or a custody evaluation. In the event that you need an evaluation, I will be happy to assist you to find a provider that offers this service.

Contacting Me/Emergency Policy

You can leave me a message on my voice mail at 503-653-5205. Always leave a phone number where you can be reached and good times to return your call. I check my messages regularly Monday through Friday. I will make every effort to return your call promptly.

Texting and emailing may be used to communicate about appointment scheduling, however, they are not guaranteed to be secure forms of communication and **are not to be used for** correspondence regarding crisis or emergencies.

**If there is a life threatening emergency, call 911 or go to the nearest emergency room.** If there is an urgent clinical matter that needs my attention, but can't wait for a return call, you may also **call the Portland Area Crisis Line at 503-988-4888 or you can call or text Lifeline at 988.**

## Agreement and Informed Consent

My signature below indicates that I have been informed of, understand and agree to the above information regarding, treatment and confidentiality, fees and insurance, appointment, cancellation, and emergency policies. I agree that I have had the opportunity to discuss the potential benefits and risks of therapy done by Linda Heins, LCSW. This consent can be revoked at any time in writing.

Name of Client _____

Signature of Client or Legal Guardian_____

Date_____

I acknowledge that I have received a copy of the privacy notice detailing HIPAA regulations. I have had an opportunity to discuss concerns and questions I have about the privacy of health information.

Name of Client_____

Signature of Client or Legal Guardian_____

Date_____

I give permission to Linda Heins L.C.S.W., LLC to release to my health insurance company information relevant to the services I have provided to you. This information may include: diagnosis, treatment plan, symptom status, treatment compliance, response to treatment, and progress toward treatment goals. I give permission to Pear Business Services, LLC to bill my insurance company for the purpose of collecting for services rendered with Linda Heins, LCSW, LLC.

Name of Client_____

Signature of Client or Legal Guardian_____

Date_____

503.653.5205
lindaheinslcsw@gmail.com
10121 SE Sunnyside Rd. Suite 300
Clackamas OR 97015

**Linda Heins**, LCSW
Licensed Clinical Social Worker

| PATIENT INFORMATION | | | |
|---|---|---|---|
| LAST | FIRST | MI | BIRTHDATE |
| Address: | City: | ST: | Zip: |
| Home Phone: | Spouse Name: | | |
| Email: | Marital Status: | | Gender: |
| Emp/School: | Occupation: | | Wk #: |
| Patient relationship to responsible party: | | | |

| RESPONSIBLE PARTY | | | |
|---|---|---|---|
| LAST | FIRST | MI | BIRTHDATE |
| Address: | City: | ST: | Zip: |
| Home Phone: | Work Phone: | | |
| Social Security No.: | Employer: | | |

| PRIMARY INSURANCE | | |
|---|---|---|
| Insured Name: | | ID #: |
| Insurance Company: | | Date of Birth: |
| Insurance Co Address: | | Phone: |
| Policy #: | Plan #: | Group #: |
| Patient relationship to insured: | | |

| SECONDARY INSURANCE | | |
|---|---|---|
| Insured Name: | | ID #: |
| Insurance Company: | | Date of Birth: |
| Insurance Co Address: | | Phone: |
| Policy #: | Plan #: | Group #: |
| Patient relationship to insured: | | |

To the best of my knowledge, all insurance information has been provided on the above form. I authorize release of any medical information needed to process this claim. I hereby authorize payment of mental health benefits to Linda Heins, LCSW, LLC. I also authorize Linda Heins to represent me, if needed, before the Oregon Insurance Commissioner. I understand that I am financially responsible for any charges not covered by insurance and for cancellation with less than 24-hours notice.

Responsible Party/s Signature _____ Patient/s Signature _____ Date _____

503.653.5205
lindaheinslcsw@gmail.com
10121 SE Sunnyside Rd. Suite 300
Clackamas OR 97015