Andie DeSha, L. P.C., N.C.C.
Counseling Services
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PROFESSIONAL DISCLOSURE AND INFORMED CONSENT STATEMENT

PHILOSOPHY AND APPROACH

My belief is that much of the change that occurs through counseling is a result of the professional relationship established between counselor and client(s) based on mutual respect, empathy, honesty and genuine support. My theoretical styles include Adlerian and Family Systems, meaning that I view clients in a positive way and I believe that all individuals have the capacity to grow, to creatively overcome their problems and to develop useful and meaningful social relationships.

I specialize in working with individuals, families, adolescents and teens. My areas of specialty often encompass issues related to anxiety, depression and diminished self-esteem. I serve individuals struggling with depression, anxiety, attachment disorders, life transitions, grief and loss, chronic illness and addictions through the use of evidence-based practices and compassionate care. In practice I take an eclectic or integrative approach. I utilize a range of interventions including motivational interviewing, cognitive-behavioral, solution-focused, dialectical-behavioral, mindfulness, relational and experiential strategies. I feel it is important to assess each client's needs and wants and tailor treatment to meet the specific needs and goals of each individual client, couple, family or group.

Possible benefits of therapy may include relief from symptoms of anxiety, depression or grief, improved relationships with yourself and others and increased satisfaction in life. While therapy's goal is to help clients have lives that they are happier with, it is still work, and may at times feel uncomfortable or difficult. Symptoms may worsen before they improve; new symptoms may arise during the course of therapy. New behaviors may upset old relationships. Therapy is not a "magic bullet," but it does have a powerful potential to facilitate growth. Your participation in therapy is entirely voluntary. If I am not ultimately the right therapist for you I will help you find the one that is, so that you may get the most possible from your therapy experience.

FORMAL EDUCATION AND TRAINING

My Master's degree is in Clinical Mental Health Counseling from Oregon State University-Cascades (2013). I am a National Certified Counselor (NCC). Additionally, I am a licensed school counselor. I am a member of American Counseling Association (ACA), American School Counseling Association (ASCA) and Oregon Counseling Association (ORCA).

LICENSURE

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession.

CANCELLATIONS, CONTACT HOURS AND SCHEDULING

I am available to return calls **Monday through Friday 10:00 a.m. to 6:00 p.m.** related to needs like rescheduling, cancellations, questions or general information. If you leave a message I will return your call as quickly as possible. I require 24-hour notice for cancelling or rescheduling an appointment. Failure to cancel in this time frame will result in a charge of the full session rate. If you are experiencing a mental health crisis, and need immediate support or emergency services outside our regularly scheduled appointments, please refer to the following resources:

- Emergency 9-1-1
- Deschutes County Behavioral Health Crisis Services 24-hour Hotline: 1-800-875-7364

EMAILS AND TEXTING

All emails become part of the client counseling records. Emails should ideally be used for brief necessary communications. Texting is for the purposes of scheduling appointments, including times and/or dates; confirming appointments; notification of late arrival; needing to reschedule; as well as requests to contact.

CONFIDENTIALITY

Our work together is confidential. What you choose to discuss with me is private and protected by federal and state laws. Except under unusual circumstances, discussed below, I will not share anything we talk about with others unless I have your written permission to do so. I will seek specific permission from you to exchange information with another party, such as a doctor, teacher or family member. A release of information will be provided for you to review and sign.

CLIENT RIGHTS

- To expect that a licensee has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics;
- To report 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, including 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 licensee case consultation or supervision; and 5) Defending claims brought by client against licensee;
- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status or socioeconomic status.

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
Email: lpct.board@state.or.us
Website: www.oregon.gov/OBLPCT
For additional information about this therapist, consult the Board's website.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Please list anyone you specifically request I **DO NOT** speak with regarding your care: _____
May I: Identify myself when I call home/cell? **Y/N** Work? **Y/N** Leave messages on your voicemail/answering machine? **Y/N**
May I correspond with you via text/email? **Y/N** *(Please note my email is not encrypted/secure)*

I hereby acknowledge that a copy of the office's **Notice of Privacy Practices, dated 10/1/16** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

_____ _____
SIGNATURE OF CLIENT (PARENT OR GUARDIAN, IF MINOR) DATE

CONSENT TO TREATMENT

I **authorize** Andie DeSha to provide counseling services to me. I understand the potential risks and benefits of counseling, and I understand that I may ask questions about my treatment and request a review of my treatment progress at any time. I agree that my request for services is voluntary and that I may discontinue treatment at any time. I acknowledge that no guarantees have been made to me regarding the results of treatment provided. I understand my rights as described above. I certify that I have read, had explained to me where necessary, fully understand and agree with the contents of this Professional Disclosure Statement and Consent to Treatment.

_____ _____
SIGNATURE OF CLIENT (PARENT OR GUARDIAN, IF MINOR) DATE

I am giving my informed consent for a minor child or legal dependent to begin treatment.

CHILD'S NAME: _____

_____ _____ _____
PARENT OR GUARDIAN SIGNATURE OF PARENT OR GUARDIAN DATE

_____ _____ _____
PARENT OR GUARDIAN SIGNATURE OF PARENT OR GUARDIAN DATE

FINANCIAL POLICY

Fees: The cost per 50 minute counseling session with **Andie DeSha MS, LPC** is **$125.**

A reduced-fee option is available for clients demonstrating financial need (subject to available openings). Pro Bono services are also offered under special circumstances.

Payment Terms: Payment is due at the time of service. If billing insurance, any copays, deductibles or coinsurance will be collected at the time of service. A monthly statement will be sent for any outstanding balances, and payment will be due upon receipt of the statement.

In situations of divorce, separation, court orders, etc. the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

Payment Methods: In addition to cash and checks, for your convenience, Visa, MasterCard, and American Express are also accepted.

Past Due Accounts: If your account becomes past due, necessary steps will be taken to collect this debt. If your account is referred to a collection agency, you agree to pay all collection costs incurred.

There is a fee (currently $25) for any **checks returned** by the bank.

All late **cancellations** and **no-shows** may incur a cancellation/no show fee. (24-hour advance notice for appointment cancellations is required to avoid charges.)

INSURANCE

Andie DeSha MS LPC is currently contracted with *PacificSource Health Plans* and *Regence Blue Cross Blue Shield* and *First Choice Health*.
Please be advised that actual reimbursement cannot be predicted, and that insurance benefits are not a guarantee of payment. It is highly recommend you contact your insurance carrier and verify your coverage for counseling services.

Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about the fees, Financial Policy, or your financial responsibility.

I have read and understand the above statements. I authorize Andie DeSha MS LPC to bill my insurance company and to release any information relating to my claims. I hereby authorize payment of benefits, otherwise payable to me, directly to Andie DeSha MS LPC.

_____ _____ _____

CLIENT'S NAME (OR RESPONSIBLE PARTY, IF MINOR) SIGNATURE OF CLIENT (PARENT OR GUARDIAN, IF MINOR) DATE