Rhonda Andrews LCSW
Individual, Child & Family Therapist
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INFORMED CONSENT STATEMENT

I. TREATMENT PHILOSOPHY

I believe as individuals and families grow and go through developmental stages, changes or crisis can occur that lead them to the point of needing some extra support, counseling, coaching and education to get through the crisis time. I believe adults are the experts on themselves, and I believe that parents are the experts regarding their own children. Therefore, utilizing individuals and parents' knowledge and expertise is a vital part of helping make positive changes. I believe that all adoption begins with a loss, and that the adopted child, the birth parents, and the adoption parents deal with the issues of loss the entire adoptive child's life. Advocacy for children's safety and well-being continues to be an important factor in my career, and I believe education is the best way to achieve this. To guide healing and positive changes for people of all ages, I sometimes blend techniques of sand and art therapies, along with the classic psychodynamic, developmental, cognitive-behavioral, systems, and play therapy theories.

Participating in therapy has both benefits and risks. It also requires an investment of your time, money, and energy in order to make the process most successful. I will begin with an assessment of you, and/or your child's, needs. After several sessions, we will develop a treatment plan in accordance with your goals and aims. It is common for individuals to feel worse, or for children's concerning behaviors to increase, in the beginning phase of treatment. As treatment continues, symptoms should be reduced and/or children's behaviors should become more positive. However, there are times when counseling does not produce positive outcomes or changes. You always retain the right to request changes in treatment or to refuse treatment for yourself, or your child, at any time. I have a strong commitment to being useful to you as your therapist, and I value any feedback about how therapy is working for you.

II. EDUCATION AND EXPERIENCE

I hold a Master's Degree in Social Work from University of Hawaii. My Bachelor's Degree is in Sociology, from the University of Oregon. I have approximately twenty years of experience working with children and families in a variety of settings. For many years, I worked in Child Protective Services in Hawaii and Oregon. Currently, I am an adjunct professor George Fox University in the Social Work Department. I have been directly involved with the adoption field for over nine years. I completed my Post Graduate Certificate in Adoptive Therapy in 2005. I am

a Registered Play Therapist, a member of the National Association of Social Workers (NASW), and a member of the Association for Play Therapy.

III. MANAGED CARE

If your health insurance is a managed care plan, you may know that it involves cooperation between client, provider, and insurance company to provide services as efficiently as possible.

Your contract with your health insurance company states that you (or your child's) mental health coverage is limited to:

1. services that are determined to be "medically necessary." Medically necessary may be defined as presentation of a covered DSM IV Axis I diagnosis (these are acute symptoms).
2. conditions that can be treated by short-term, problem-focuses, goal-oriented approaches whenever possible

This means that your insurance will cover a limited number of office sessions to work on your (or your child's) problem as intensely as possible with the focus of eliminating acute symptoms. I am contracted with your insurance company to provide my services within these conditions. This practice reviews cases for quality assurance. Your case may be reviewed by a utilization/quality assurance group set up by the insurance company or members of my practice. I will maintain your confidentiality in this process.

IV. OFFICE POLICIES

Appointments are approximately 45 minutes in duration. If you need to cancel, please try to call at least 24 hours before your scheduled appointment. If you forget your appointment, please call as soon as possible to let me know whether or not you plan to continue treatment. Please try to be on time to your appointment. If you are late, you are reducing your own session time.

If I am working with your child, who is under the age of 10 years old, I ask that you stay somewhere in the building or the building parking lot during the appointment time.

If I have not had any contact with you for 90 days, I will assume that your file is closed, and you are no longer my client. At anytime in the future, you may make another appointment.

In case of an emergency, you may call the emergency back-up pager; 503-237-0487. If you choose to use this pager number after-hours or on weekends, there will be a $30.00 charge per call, which is not billable to your insurance company. Occasionally, another therapist may be providing back-up services for Rhonda Andrews, and there is not guarantee of talking with Rhonda when you choose to use the back-up pager. The back-up pager service is only available to current clients. If unable to access the back-up pager due to financial difficulties, other arrangements will be made with Rhonda prior to an emergency.

There is also a Crisis Hotline number: 1-800-560-5535. This is available to you for any mental health emergency. It is free of charge and is available twenty-four hours a day. Calling your primary care physician, or the police, are also options. You may leave a message on my office voice mail at any time, and I will return the call as soon as possible, or by the next business day that I am in the office.

V. CLIENT RIGHTS

As a social worker, I adhere to the NASW Code of Ethics. My primary responsibility is to my clients. I believe in self-determination and participation. I believe everyone has the potential to grow and change, and that both the social worker and the client take an active role in this process. Participation involves open communication and developing mutually agreed upon treatment goals.

I believe that all people have the right to dignity and self-worth. I will not practice nor condone any form of discrimination on the basis of race, ethnicity, gender, sexual orientation, or socio-economic status.

Clients have the right to individualized services. As a social worker, I will provide my clients with accurate and complete information regarding the extent and nature of the services available to them.

VI. CONFIDENTIALITY

I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose to anyone anything you tell me, nor even the fact that I have seen you, without your written permission by way of a signed release of information form. There are a few exceptions to these standards:

- I am legally required to report cases of child, elder, and disabled abuse.
- I am legally required to act so as to prevent physical harm to yourself or others where there is "clear and imminent" danger of that happening.
- I may have to release clinical information regarding you to insurance carriers as required for payment or review of your claim.
- I may have to release your records when ordered to do so by court subpoena. However, I will discuss this with you before hand and request written release from you if I judge this to be in your best interest.
- I regularly consult with colleagues about their work. If your case were ever discussed, it would be confidential and without your name or identifying information.

VII. RELEASE OF INFORMATION

Please sign below to show that you have read and understand this Informed Consent Statement and that you authorize the release of your clinical record information to your insurance company for the purpose of healthcare credentialing, utilization and quality assurance review.

____
Client's Signature Date

____
Parent or Guardian's Signature (if client is a minor) Date

____
Parent or Guardian's Signature (if client is a minor) Date

____
Therapist's Signature Date

VIII. CONSENT TO TREATMENT

Please sign below to show that you have read and understood this Informed Consent Statement and that you consent to the recommended treatment and/or grant permission for treatment to be provided to yourself or your child(ren).

____
Client's Signature Date

____
Parent or Guardian's Signature (if client is a minor) Date

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Parent or Guardian's Signature (if client is a minor) Date

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Therapist's Signature Date

IX. PATIENT PRIVACY (HIPPA)

__________ I have read the HIPPA policy regarding how clinical information about you may be used and disclosed and how you can access this information.

__________ I declined a copy of the HIPPA Policy that Rhonda offered me.

__________ I received a copy of Rhonda's Informed Consent and Fee Agreement forms.

__________ I declined a copy of Rhonda's Informed Consent and Fee Agreement forms.