



# Bill McClain, LCSW

*Child, Family, and Individual Counseling*

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## Statement of Informed Consent

This document describes some of the policies and procedures that I have developed as part of my psychotherapy practice. At the end of the document, you are asked to sign to indicate your understanding and agreement to counseling services under these conditions. Please read each point carefully, and be sure to ask about anything that may be unclear to you.

### **Professional Status**

I have worked with children, adults and families since 1997. I have a Master's Degree in Social Work and I am a Licensed Clinical Social Worker #L3948. As a Licensed Clinical Social Worker, I am allowed to practice psychotherapy with children, adolescents, adults and families as long as I comply with the regulations of the Oregon State Board and ethical guidelines from the National Association of Social Workers (of which I am a member).

### **Contact Information and Emergencies**

My private practice hours are by appointment. On occasion, you may find it necessary to contact me by phone outside of our regularly scheduled appointments. I am often not immediately available by phone, due to being involved in sessions with other clients and other professional and personal responsibilities. When I am not available, you can leave a confidential voicemail message at (541) 914-1719. I check my messages regularly and will do my best to return your message in a timely manner during business hours.

In the event of an emergency, you may leave me a message informing me of such but I suggest you also consider seeking more immediate assistance. Community crisis resources include:

For Children and Adolescents:

Mental Health Crisis Team 1-888-989-9990

For Adults:

White Bird (541) 687-4000 or local emergency room. If needed call 911.

If I am on an extended leave, I will generally have a colleague provide back-up assistance for clients in need. In this event, I will provide you with the practitioner's name and number and you may seek them out for services.

### **Psychotherapy Risks and Benefits**

Participation in psychotherapy has been shown to significantly benefit people who undertake it for personal growth, symptom reduction, behavioral change, self-development, skill development, improvements in relationships, increased feelings of well being and reduction in feelings of distress, resolution of specific problems, and the exploration of personal issues and concerns that influence daily life and relationships.

Psychotherapy does, however, carry some risks. Risks may include: uncomfortable feelings which can result from the exploration of difficult or unpleasant aspects of past or current experiences or discomfort from attempts to stretch oneself by engaging in new behaviors, relational skills and coping strategies. For children and adolescents this may manifest in behavioral reactions. The most notable risk is a lack of positive impact on presenting concerns.

Best outcomes of psychotherapy are typically associated with the following:

- Consistent attendance, active effort and collaboration, both on your part as the client and my part as the therapist.
- A positive relationship between therapist and client. Therefore, if at any time you feel uncomfortable or dissatisfied with our relationship or work, it is important that we discuss this so that we can make the appropriate adjustments to our work together or, if needed, I can assist you with referral to another professional.

### **Appointments and Scheduling**

After the initial intake appointment(s), which typically last a total of 60-90 minutes, each appointment will be approximately 50-60 minutes in length. You will be responsible for letting me know at least 24 hours in advance of any cancellation for a scheduled appointment. There are no fees charged for sessions cancelled in advance. However, you will be charged for sessions you do not attend and do not call to cancel in advance. If your fee is being paid by another payer such as a community agency or insurance company, they will not be billed for such sessions and these fees will be solely your responsibility. On occasion, I may also have to cancel or reschedule sessions. In such cases, I will attempt to contact you at least 24 hours in advance whenever possible.

### **Fees**

Fees, including any co-payment, are due in full at the conclusion of each session, unless we specifically agree to other arrangements. My fee is typically \$110 per 50-60 minutes. Intake sessions \$190 per 75-90 minutes and family sessions \$150 per 50 minutes. In addition, there may be charges for specialized assessments, written documents such as certain kinds of letters, reports, treatment plans, case management services and/or telephone calls. I will inform you of these when applicable prior to provision of service.

For those whose fees are being paid by another payer such as a community agency or insurance company, it is your responsibility to be apprized of whether your treatment or other recommended services will be reimbursed. Any unpaid fees are the responsibility of the client. If you have questions about third party billing, or need some assistance, please discuss this with me. Please see attached consent form for more information on issues related to third party payment.

### **Confidentiality**

I will treat what you share with me in great care. Law protects confidentiality of all communications between a client and a therapist as well as documentation and records. Confidentiality guidelines are determined by Oregon State Law, federal HIPPA guidelines, and my professional social work ethics.

Please note, Oregon State Law asserts certain exceptions or limits to confidentiality for cases in which there is potential harm to the client or others.

- I am mandated by law to report any suspected abuse to a child or certain adults.
- In situations in which I believe you represent a serious bodily harm to yourself or others, I may contact appropriate authorities or seek hospital treatment for you on your behalf.
- If there becomes some legal involvement in your case, I may be court ordered to release records or testimony. In such cases, I will typically attempt to assert confidentiality, however, a judge may overrule this if he or she determines that this information is necessary. I strongly discourage the use of treatment with me to further legal goals such as custody evaluation or abuse investigation. The purpose of my services is to promote client well-being. If you are seeking services for legal reasons, we should discuss whether a referral to another resource instead of or in addition to your work with me is

appropriate.

At times, coordination of assessment or treatment with other professionals or important people in your life may be beneficial to treatment. This would require me to exchange treatment information with them. In such cases, I will discuss this with you and you should know that law requires I obtain prior written permission from you before releasing any information about our work together. You have the right to refuse to give permission or revoke permission in writing at any time. *In general, the sharing of information is done for the sole purpose of benefiting your treatment.*

I am required to keep a file of our work together for clinical record and treatment operations. All information about you will be under my supervision and kept in a locked file in my locked office.

Please refer to the attached privacy notice for more detail regarding federal confidentiality guidelines. Please initial here to indicate you received this Notice of Privacy Practices.

(Initial here) \_\_\_\_\_

### **Child/Adolescent Issues**

Providing services to children and adolescents may present special challenges in relation to consent to treatment and confidentiality.

By Oregon Law, the custodial parent or guardian is the only person who can provide consent for treatment for children under 14 years old. Please note that a noncustodial parent is only legally able to provide consent for treatment in the case of emergencies when the custodial party is not available. Both custodial parents/guardians and noncustodial parents have the same rights regarding access to treatment information such as discussing treatment with me or reviewing treatment records directly pertaining to the identified client. This does not include access to information about others who may be referred to in the records during the course of treatment such as other parents, family members, etc.

It is always my goal to increase connection and communication between youth and their parents whenever possible. However, establishing a trusting relationship with a child or adolescent client may require me to sometimes keep some information shared in therapy confidential from parents. Please note, any information that includes threat of harm to a child/adolescent or other will be shared with parents except when to do so would put a child/adolescent in harm's way. Always, I encourage parents to share any information or concerns with me about the child/adolescent that would be helpful in understanding them or their treatment needs. Similarly, parents are always welcome and encouraged to present me with any questions or concerns about the therapy process for discussion and shared decision-making.

### **Statement of Informed Consent**

By signing this Statement of Informed Consent, I acknowledge that I have read the statement, agree to abide by its terms, and have had any questions or concerns about its contents addressed by Bill McClain, LCSW. Furthermore, my signature below indicates that I have voluntarily agreed to enter myself or my child into treatment with her. I understand that, by law, I need not sign or enter into this agreement and I may choose to discontinue treatment at any time.

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Client Name (please print)

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Signature of client or legal guardian and date