Life Discovery Counseling Services
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Statement of Understanding and Consent for Treatment

Psychotherapy is not like a medical doctor visit; it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

In couples therapy, if you and your partner decide to have some individual sessions, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not say anything you wish kept secret from your partner*. You will be reminded of this policy before beginning such individual sessions.

Life Discovery Counseling Services, its employees and contractors, are generally available by appointment only. You may call and leave a confidential message at any time and we will return your call as soon as possible. Our policy for after-hours coverage is to leave a message and we will return your call the next business day. If you are in need of urgent or emergency services after hours, contact your local social services, crisis line (Washington County: 503-291-9111) or dial 911.

Please understand that information obtained from you is confidential under Oregon law. Information may not be shared with anyone without your permission except in the following circumstances:

1. When a court order is received.
2. When there is reasonable cause to believe that you will hurt yourself or someone else.
3. When there is reasonable suspicion to believe that abuse/neglect of a child, elderly person, disabled person, or any animal is occurring or has occurred.
4. Information necessary for billing purposes, justification for treatment, and resolution of a complaint.

Your ***INITIALS*** beside each of the following indicates your understanding and consent for treatment:

_____ I understand that I may withdraw consent for treatment at any time.
_____ I understand and have reviewed statement of financial responsibilities.
_____ I have received a professional disclosure statement.
_____ I have received a copy of HIPAA's Notice of Privacy Practices.
_____ I understand that any records sent to or retrieved from other professionals will be marked and directed as "NO FURTHER DISCLOSURE" to protect your privacy.

Your signature indicates that you understand this "Statement of Understanding and Consent for Treatment" and agree to the above. I hereby give Life Discovery Counseling Services, LLC consent to provide my treatment.

_____	_____	_____
Print Name	**Client Signature**	**Date**
_____	_____	
Clinician Signature	Date	