Wendy G. Newton, PsyD
3939 NE Hancock Street, Suite 314, Portland, OR 97212
Phone: (503) 869-9092 FAX: (503) 473-8273

Office Policies and Consent to Treatment

This is a description of my policies and practices -- please read it carefully. If you have any questions or concerns, feel free to discuss them with me before signing this agreement for treatment. You will receive a copy of this form for your records, and I will keep a signed copy in your file.

Introduction: I am a licensed psychologist with a doctoral degree in Clinical Psychology from Pacific University. I have been in the mental health field for over 15 years. I use a cognitive-behavioral orientation and specialize in helping adults manage painful emotions, relationship issues, and problematic behaviors. Therapy is often very helpful for these kinds of problems.

Risks and Benefits: Most people benefit from treatment as seen with the resolution of problems, reduced symptoms, and a better understanding of yourself and others.

Psychotherapy can also have some risks. Since therapy often involves discussing difficult feelings and aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and frustration at times. These feelings usually subside as the work progresses. In addition, although most people benefit from therapy, there are no guarantees of what you will experience.

The length of treatment varies considerably and can be difficult to predict. I will work with you to develop a time frame for treatment taking into consideration not only the problems you bring into therapy but also your goals and any financial considerations you may have.

If you have any questions about my procedures or practice, please feel free to ask at any time. It is important that you know that you always have the right to request changes in treatment, refuse treatment at any time, or request the names of other providers.

Appointments: Sessions are 50 minutes long. If you are unable to keep your appointment, please give me as much notice as possible. Because your appointment time is reserved exclusively for you, there is a 50% charge for appointments not cancelled 24 hours in advance; insurance companies will not pay for missed sessions.

Confidentiality: In general, the law protects the privacy of communications between a psychologist and a client. I will not disclose to anyone anything you tell me without your written permission. However, there are a few exceptions to these standards. For example, in some situations I must:

1) Report if there is reasonable cause to believe that a child, a person with disabilities, or an elder has suffered abuse;
2) Take steps to prevent physical harm to you or others when there is 'clear and imminent' danger of that happening;
3) Release your records when ordered to do so by court subpoena;
4) Release clinical information about you to your insurance carrier for treatment authorization, payment, or review of your claim;
5) Consult with other professionals about your case in order to provide you with the best treatment I can. During clinical consultations, I make every effort to avoid revealing your identity;
6) I may use a fax machine to send treatment plans, reports, or evaluations to your insurance company, specific agencies or other providers, and,
7) In the event of my death, Dr. Georgia Wilcox, Psy.D., will facilitate the disposition of my records.

Telephone Calls: You may leave messages for me at (503) 869-9092 at any time, day or night. I check for messages several times each day, and I will return calls as soon as possible. Phone calls that are over 15 minutes in length will be charged at $10 per call.

Emergencies: I am often not immediately available by telephone. If you are not able to reach me immediately and need urgent help, you can call the 24-hour crisis line for your community: *(503) 988-4888 (Multnomah County); (503) 291-9111(Washington County); (503) 655-8401(Clackamas County),* or go to the nearest hospital emergency room. When out of town, I will arrange for another psychologist to be available for emergencies.

HIPAA Notice of Policies and Practices: I am required by Federal Law (Health Insurance Portability and Accountability Act, known as HIPAA) to protect the privacy of personal information. You may request a copy of this notice at any time, and a copy will be offered to you at the first session.

Your signature below indicates that you have read, understand, and agree to the policies stated above, and that you consent to treatment under those conditions:

Client Signature: _____Date_____

Your signature below indicates that a notice describing the HIPAA privacy act has been made available to you.

Client Signature: _____Date: _____

___ A copy of this form has been provided to the client.