



Fawn Gonzales, LCSW
Independent Practitioner

CLIENT INFORMATION FORM

Client Name _____ Date of Birth _____ Email _____

Gender Identity _____ Preferred Pronoun _____

Mailing Address _____

Home Phone _____ Street _____ City _____ Zip _____
Cell Phone _____ Okay to leave a message? _____

Responsible Party _____ Relationship to Client _____

Whom to contact in case of emergency _____
Name _____ Phone _____

If you have insurance, it is your responsibility to contact your insurance company to find out what portion of the fees will be covered by your plan. If you would like me to bill your insurance company for you, please provide the following information and a copy of your insurance card.

Name of Insurance Company _____ Plan Type _____

Subscriber's Name _____ Subscriber's D.O.B. _____

Subscriber's I.D. # _____ Group I.D. # _____

Subscriber's Employer _____ Has the yearly deductible been met? _____

Co-pay Amount _____ If you have additional insurance coverage, name of secondary insurance _____

Payment/co-payment is required at the time of service. Cash and checks preferred. Credit cards are also accepted with an additional nominal fee charged by Square, Inc. Fees for service are \$275 for an initial intake, \$245 for a 60-minute session, \$185 for a 45-minute session, and \$125 for a 30-minute session. I understand that I am ultimately responsible for these fees, and agree to pay any balance not covered, or disallowed by insurance. I further understand, and agree that I will be charged 50% for the time reserved if I do not show for a scheduled session or fail to cancel with 24 hours notice. I will be charged 100% for missed sessions thereafter that I fail to cancel with 24 hours notice.

I hereby authorize release of any personal information necessary to process my claim, including my diagnosis. I understand that this information may become a permanent part of my insurance records. I authorize payments of benefits directly to Fawn Gonzales, LCSW.

Signature of Financially Responsible Party _____ Date _____

I have read and I understand the Notice of Privacy Practices that was provided to me.

Signature of Client and/or Legal Guardian _____ Date _____

INFORMED CONSENT STATEMENT

Treatment Philosophy:

Psychotherapy has both benefits and risks. The process requires an investment of your time and energy in order to make the process of therapy most successful. An evaluation of your needs will help me to develop a treatment plan in accordance with your goals and aims. Occasionally individuals may go through periods in therapy that may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This is normal and should subside as the work progresses. Remember, you always retain the right to request changes in treatment or to refuse treatment at any time.

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 your mental health covers is limited to: 1) Services that are determined to be “medically necessary.” Medically necessary may be defined as presentation of covered DSM 5
2) Conditions that are able to be treated by short-term, problem focused, goal oriented approaches whenever possible.

This means your insurance company will cover a limited number of office sessions to work on issues related to the diagnosis you meet criteria for as intensely as possible with the focus of eliminating symptoms. I may or may not be contracted with your insurance company to provide my services within these conditions. Your case may be reviewed by a utilization review quality assurance group conducted by your insurance company.

Legal Proceedings, Court & Minors:

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. In addition, non-custodial parents have equal rights to access their child's records.

Although I do provide therapy services for families, I am not a custody or visitation evaluator and will not make any recommendations or attend court hearings pertaining to those matters. Should I ever be subpoenaed for any legal proceedings, I will charge a professional consultation fee of \$250/per hour that is not billable through your insurance. Services such as chart reviews, phone calls, report writing, speaking to lawyers, attending and waiting for any court hearings, etc. will be part of this consultation fee.

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records in order to provide you an expectation of some privacy. If they agree, I will provide general information unless I ascertain there is a high risk that you will seriously harm yourself or someone else in which case I will notify them of my concern.

Termination:

If you have not been in session for therapy services for 90 days I will retire your file and consider your case terminated from treatment for the current episode of care.

How To Reach Me & Emergency Contacts:

You can leave messages for me on a confidential voice mail at (541) 944-7711. Your call will be returned promptly. If experiencing a mental health emergency, dial 9-1-1. You can also call Jackson County Mental Health at (541) 774-8201; or Josephine county Mental Health at (541) 474-5365; or the National Suicide Prevention Lifeline at 1-800-273-8255

Please sign below to show that you have read and understand this Informed Consent Statement.

Client Signature

Date

Signature of Parent, Guardian,
or Legal Representative

Date

THERAPY CONTRACT

Confidentiality

Everything we discuss in session will be held confidential with the following exceptions:

- I am required by law to report suspected child, elder and disabled abuse
- I will breach confidentiality if I feel that you are in imminent danger of harming yourself or someone else. Or if you are experiencing a medical emergency and I need to help you.
- I may consult with your health providers about your case.
- I may need to present information from your records in court.
- I will need to release information about you to your insurance company in order to process claims or respond to requests/authorizations/audits. This may include diagnosis and treatment plan, or your entire record and this information may become a permanent part of your insurance records.
- Waiver of confidentiality: if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at my office may become a matter of public record.

Client Rights

As a client of a Licensed Clinical Social Worker in the State of Oregon and a member of the National Association of Social Workers, you have the following rights:

1. To expect that your therapist has met the minimum qualifications of training and experience required by state law.
2. To examine public records maintained by the Oregon State Board of Clinical Social Workers, 3218 Pringle Rd. SE Suite 240, Salem, Oregon 97302 and to have the board confirm your therapist's credentials.
3. To obtain a copy of the code of ethics.
4. To report complaints to the board.
5. To be informed of the costs of services prior to receiving services.
6. To be free from discrimination on the basis of race, religion, gender or any other protected category while you are receiving services.
7. To review or request a copy of your records.
8. To not be exploited by your therapist for their own personal benefit or advantage.
9. To be assured privacy and confidentiality with the previously mentioned exceptions.

Your Responsibilities

1. To keep all scheduled appointments and to contact me at least 24 hours in advance to cancel or reschedule.
2. To attend all sessions alcohol and drug free.
3. To make all your payments/co-payments completely and on time.
4. To be active in the treatment process.

Please sign below to show that you have read and understand this Therapy Contract.

Signature of Client and/or Guardian

Date

Fawn Gonzales, LCSW

Date

*I would like a copy of this form:

Yes

No