Telehealth Informed Consent Form

I,, _____ consent to receive psychological treatment via telehealth with Beth Westbrook, PsyD to facilitate both my access to professional services and my treatment goals. I understand that telehealth services may include evaluation, assessment, consultation, treatment planning, as well as psychological coaching and counseling. Telehealth will occur primarily through HIPAA compliant interactive audio, video, telephone and/or other audio/visual communications. I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.

2.The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand the information released by me during the course of my sessions is confidential. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

3.I understand that there are risks and consequences from telehealth including, but not limited to, the possibility, despite reasonable efforts on the part of Beth Westbrook, PsyD that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth-based psychological services may not be as comprehensive as in-person services. I understand that if my psychologist believes I would be best served by other interventions (i.e. in-person treatment), I will be referred to a psychologist or psychiatrist who can provide these services in my area.

4.By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio, video and/or computer-based psychological or psychiatric services. If I am in crisis or I am experiencing a medical or psychiatric emergency, I should immediately call 911 or go to the nearest hospital or crisis facility.

5.By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic or manic symptoms, experiencing a life threatening or emergency situation, abusing drugs or alcohol or experiencing other concerns which may present a risk to your safety.

I have read and understand the above information and agree to participate in telehealth services with Beth Westbrook, PsyD.

Client's Signature: _____

Date: _____

Client's Printed Name: _____

Client's Address (physical location during telehealth sessions):

_____

Emergency Contact Name/Telephone Number: _____

Dr. Beth Kaplan Westbrook
2250 NW Flanders, Suite 105
Portland, OR 97210
503-222-4031
www.bethkaplanwestbrook.com

PsyD, Clinical Psychology (Pacific University), 1991
Clinical Psychologist, Oregon License #1051, 1993 - present
Registered Dance/Movement Therapist, #1984-ADTR-38 (1984-2005)
Certified, Child & Adolescent Psychotherapy (Washington School of Psychiatry, Wash, DC)
Certified, Group Work, St. Elizabeth's Hospital (Washington, DC),
Certified Clinical Mental Health Counselor (National Board for Certified Counselors, #33890))
Health Evidence Review Commission, Governor Appointee, 2012-2017, State of Oregon

Professional Disclosure Statement

I abide by all rules and standards for training, experience and ethics required by the Board of Psychologists Examiners (Salem, OR). I am a member of the Oregon Psychological Association (Portland, OR), and the American Psychological Association (Washington, DC).

- In addition to private practice, I consult to the Medical Society of Metropolitan Portland (Wellness Program) and Health Professionals Service Program, State of Oregon (formerly Diversion Program for Health Professionals). My theoretical orientation is psychodynamic in individual, group and couples psychotherapy.

- You have a right to privacy as defined by rule and law, including the exception to confidentiality of information obtained in the course of services that include the following: reporting suspected child abuse, reporting imminent danger to client or others, reporting to relevant agencies, licensee consultation or supervision, defense of claims brought by client against licensees, to be free from discrimination on the basis of race, religion, gender, or other unlawful, category while receiving service.

Fees

- $250 per initial session
- $190 per 45 minute session, payment is requested at the beginning of each session.
- $20 monthly billing fee
- Fee charged for all missed sessions with the exception of vacations.
    - *I keep a regular time open for you. If you know ahead of time that you will miss an appointment I will attempt to reschedule with you within the same week when possible.*
- Insurance accepted, bills due over 90 days are sent for collections.
- Insurance will not cover missed appointments.
- Please make payments by the end of each month to avoid 1.5% interest charges.
- Please verify your insurance coverage including any pre-authorized requirements, claims addresses and co-pay responsibility. Initial below that you are fully responsible for all fees incurred regardless of insurance coverage for the services provided under this agreement.
- _____**(initial here please)**

All information in private sessions is confidential except if danger to self or others is present. Parking is available behind the building at no cost to you during your appointment. Please review the Notice of Privacy Practices in the waiting room, your signature below indicates that you have been provided with this information.

Consent to treatment:

Please sign..... **Date**.....

Statement of Understanding for Couple Therapy

Beth Kaplan Westbrook, PsyD
2250 NW Flanders, Suite 105
Portland, Or 97210

Couple therapy starts with an assessment of the relationship past and present.

We understand that information discussed in couple's therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners.

We agree not to subpoena the therapist to testify for or against either party or to provide records in a court action.

By entering into couple's therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful in order to reach our goals.

We accept that such changes can have both negative and positive effects and agree to clarify and evaluate potential effect of changes before we undertake them.

There will be times when the therapist may appear on either person's side, but the therapist is really on the side of the marriage.

Phone calls between sessions should be used for making appointments and emergencies only, not to inform the therapist of developments or to obtain extra counseling between sessions.

If the relationship breaks up and either or both of you wish to re-contract with the therapist for individual counseling, it will be done at the discretion of the therapist, and will require agreement of all parties. In some circumstances, a referral will be made to another therapist.

If the therapist sees either member of the couple for individual sessions as part of couple treatment, secrets will not be kept and the therapist reserves the right to pass on information that furthers therapeutic goals.

Individual sessions will occur only when planned as part of the couple treatment. If one of you cannot make a session, please call the therapist so that an appropriate plan can be made. Do not just show up without your spouse / partner, unless that has been planned.

Since session time is limited to 45-50 minutes, try to be concise in presenting your thoughts and feelings.

Therapy works best if you strive for closure in your communications, that is, a point of satisfaction that you have said what you need to say and asked for what you need to ask for.

We agree to the above guidelines.

Signature of both partners

Printed name	Signature	Date

Printed name	Signature	Date

Beth Kaplan Westbrook, PsyD
Payment for Services Form

Payment in full is due at the end of each month.

- If you are using your insurance, I will bill the company for your convenience.
- Your copay/deductible or full fee is due at the end of each month,
- If this is prohibitive for you, please speak with me right away to see if another arrangement is possible.

Methods of Payment

- Cash
- Check
- Money Order
- Crediti Card: *VISA, MasterCard or Discover will be billed ONLY in the event of an unpaid bill after a period of 3 months.*

Credit Card Information
Even if you plan to pay by some other method at each visit, I still require your credit card information to insure prompt payment. If you do not pay the full amount you owe, your credit card will automatically be charged after a period of 3 months for the entire amount you owe.

VISA☐ **MasterCard☐** **Discover☐**

Name on the Card:_____

Billing Address for Card Holder: _____

Card#: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiration Date: _____ (MM/YY)

Security Code (last 3 digits on back of card): _ _ _

☐ **PLEASE INITIAL** I plan to pay my balance in full at the end of each month by check, cash or money order. Use my card ONLY to automatically pay any balance when I have not paid the balance due at the end of 3 months. I understand that communication with other providers regarding my care will be charged to my card as well as any credit card service charges.

I authorize payment for (client name): _____

Your signature:_____ **Date:**_____

Print your name:_____

Ver. 05/14

Adult Wellness Assessment

Date:
Name:
DOB
Clinician

Please rate how much the following bothers you:

	Not at all	A little	Somewhat	A Lot
Trouble sleeping	☐	☐	☐	☐
Feeling blue/sad	☐	☐	☐	☐
Hopeless about the future	☐	☐	☐	☐
Everything is an effort	☐	☐	☐	☐
No interest in things	☐	☐	☐	☐
Nervous	☐	☐	☐	☐
Fearful or afraid	☐	☐	☐	☐
Pounding or racing heart	☐	☐	☐	☐
Difficulty at home	☐	☐	☐	☐
Difficulty socially	☐	☐	☐	☐

Please rate if you agree with the following:

	Strongly Agree	Agree	Disagree	Strongly Disagree
I can deal with my problems	☐	☐	☐	☐
I can accomplish things	☐	☐	☐	☐
I feel good about myself	☐	☐	☐	☐
I can count on others for help	☐	☐	☐	☐

How is your health? Excellent☐ Very Good☐ Good☐ Fair☐

Do you have a serious medical condition?

Asthma☐ Diabetes☐ Heart Disease☐ Back pain/Chronic Pain☐ Other Condition☐

If Other, please list here:

In the past 4 weeks:

How many drinks of alcohol did you have? ☐☐

Have you felt you should cut back on drug use or drinking? Yes☐ No☐

Have others annoyed you by criticizing your drug use or drinking? Yes☐ No☐

Have you felt bad about your drug use or drinking? Yes☐ No☐

Is there anything else that you would like your clinician to know?

Adult Wellness Assessment

Date:
Name:
DOB
Clinician

Please rate how much the following bothers you:

	Not at all	A little	Somewhat	A Lot
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Feeling blue/sad	☐	☐	☐	☐
Hopeless about the future	☐	☐	☐	☐
Everything is an effort	☐	☐	☐	☐
No interest in things	☐	☐	☐	☐
Nervous	☐	☐	☐	☐
Fearful or afraid	☐	☐	☐	☐
Pounding or racing heart	☐	☐	☐	☐
Difficulty at home	☐	☐	☐	☐
Difficulty socially	☐	☐	☐	☐

Please rate if you agree with the following:

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I can accomplish things	☐	☐	☐	☐
I feel good about myself	☐	☐	☐	☐
I can count on others for help	☐	☐	☐	☐

How is your health? Excellent☐ Very Good☐ Good☐ Fair☐

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Is there anything else that you would like your clinician to know?