Amanda P. Orton
Licensed Marriage and Family Therapist
Oregon License No. T0643

Billing Information and Treatment Commitment

Assignment of Benefits

I hereby authorize Amanda P. Orton, LMFT to bill my insurance company directly. I authorize my insurance to pay the above provider the benefit accruing to me under my mental/medical healthy policy for professional services rendered. I understand I am financially responsible for charges not covered by this assignment. I also authorize my insurance and/or the above provider to relay any information necessary to process my claim. I understand I am responsible for obtaining prior authorization for treatment for my insurance carrier and responsible for co-payment amounts and deductibles as set by my benefits plan. At any time during treatment should I become ineligible for insurance coverage, I will notify the provider and I understand I will become responsible for 100% of the bill.
Initials: _____

Co-payments/payments

Your co-payment/payment is due at the time the service is rendered. I accept cash, checks or paypal only.
Initials: _____

No-Shows

Missed appointments are not covered by your insurance and the charges associated with them are your responsibility. Your appointment is solely for you. If you are going to be more than 10 minutes late, please call and let me know. If you need to cancel, please call 24 hours in advance or you will be billed ***$40.00*** for a no show (see office policy for more details).
Initials: _____

Emergency Access

My availability after hours is limited. However, if you believe your life situation has become too difficult or painful, I can be reached via phone at **541-393-9008**. If you can not reach me, you can contact **1-800-991-5272. You will be billed at the regular rate of $80 per hour.**
Initials: _____

Limits of Confidentiality

All information between therapist and patient is held strictly confidential, however, with these legal exceptions:

1. The patient authorizes a release of information with signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents a physical danger to self (Johnson v. County of Los Angeles, 1983).
4. The patient presents a danger to others (Tarasoff v. Regents of University of California, 1967).
5. When child or elder abuse or neglect is suspected (Welfare and Institutions and/or Penal Code).

In the latter two cases, the therapist is required by law to inform the potential victims and legal authorities so that protective measures can be taken. All written and spoken material from any and all sessions is confidential unless written permission is given to specific person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling session.

Initials: _____

Treatment Philosophy

The two specified treatments practiced by this therapist are Cognitive Behavioral Therapy and Psychodynamic Therapy. A treatment goal or several goals are established after a thorough assessment. All treatment is then planned with goals in mind and progress is made toward accomplishment of the goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience success.
Initials: _____

Treatment Consent

I authorize and request my therapist to carry out assessment, treatment and/or diagnostic procedures within the scope of her license, which now or during the course of treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request. I also agree while the course of my treatment is designated to be helpful, my therapist can not make guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and will be worked on between my practitioner and myself.
Initials: _____

Consent to Treat Minor

If client is a minor: I consent for _____ DOB: _____ to be treated by the provider named in the letterhead above. I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the therapist to deliver mental health care services to the minor. I also understand all the policies described in this statement apply to the minor I represent.
Initials: _____

_____ _____
Signature of Client or Guardian **Date**

I, the therapist have discussed the issues above with said client and/or his legal guardian. My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give information and willing consent.

_____ _____
Signature of Therapist **Date**
Amanda P. Orton, LMFT