Johanna Rayman, LCSW, GCFP - Independent Practitioner
Licensed Clinical Social Worker, License # L3843 · Guild-Certified Feldenkrais Practitioner[cm]
1611 NE 16th Ave · Portland, OR 97232 · 503-380-5437 · johanna@johannarayman.com

OFFICE POLICIES AND INFORMED CONSENT: Mental Health Evaluation Only

Important information about my practice and your rights and responsibilities as a client

OFFICE POLICIES

Appointment for mental health evaluation: This appointment has to do with an evaluation that you have requested for a specific matter and is not psychotherapy. If you decide that you want to continue as a therapy client, we can discuss this separately if I have room in my practice.

Fees & Insurance: Usually it takes 2-3 sessions for me to gather the information for an evaluation. If your insurance pays for this service, I can bill your insurance and you will be responsible for copayment or deductible, if any. If you are paying for this yourself, I charge per session. My full fee is $125.00, and I do offer some discounted fees, if you are interested in this please ask. I do not charge an additional fee for writing the report.

Missed appointments / Late cancellations / Late arrivals:
- If you need to miss an appointment, I ask **at least 24 hours' notice for cancellations** so I can offer the space to another person. Insurance providers do not cover missed appointments.
I charge a $50 fee if a session is missed without 24- hour notice (except for OHP or CVC clients).
- If you arrive late for a session, you will still be responsible for the full copay or fee for the session. Generally, I will wait 15 minutes; after that time, if I haven't heard from you, I may not be available.

Communication between appointments: I do my best to return calls within 24 hours. I won't return "missed calls" when no message is left. E-mail and texts can be used for scheduling; however, I don't conduct therapeutic conversations by email or text because they do not allow for tone of voice etc. to be a part of the conversation. Also, be aware that e-mails and texts are considered a legal part of your medical record if your record is ever requested/subpoenaed, and I am required to keep them.

Emergency situations: If an emergency situation arises and I have not been able to respond, please call the county crisis line below, or go to your nearest emergency room.

CRISIS LINES
Multnomah: 503-988-4888
Washington: 503-291-9111
Clackamas: 503-655-8585
Clark: 360-696-9560

SUICIDE HOTLINE
If you are having suicidal thoughts, please let me know because I would like to support you.
Oregon suicide prevention hotline: **1-800-273-TALK (8255)** or chat at http://www.suicidepreventionlifeline.org/

WARM LINES provide peer counselors who are trained to listen but are not certified mental health providers. Oregon: **1-800-698-2392** Washington: **1-877-500-9276**

INFORMED CONSENT
You have the right to know your rights and responsibilities as a client, and I must ask for your consent before providing services.

Your rights
You have the right to be treated with dignity and respect; to express spiritual or political beliefs without any effect on your treatment; to refuse any therapeutic or diagnostic method; to have any service explained, including expected outcomes and possible risks; to receive information about decisions being made about your care; to have your Protected Health Information kept confidential, as described below; and to file grievances if dissatisfied with your treatment. My license is under the Oregon State Board of Licensed Social Workers.

Confidentiality
Your treatment information is protected by State and Federal law. I will share your information in a manner consistent with State and Federal laws and my Code of Ethics. This is described in more detail in the attached Notice of Privacy Practices (HIPAA)
There are several important legally mandated exceptions to confidentiality:

1. I may be required to report suspected abuse
2. I may be required to report if you become a danger to yourself or others
3. I may be required to disclose information related to a legal proceeding (court order/subpoena)

Other confidentiality issues that may come up:
-It is possible that we may inadvertently see each other in public settings outside of my office. I will not initiate contact with you in public. However, if you greet me, I am happy to respond.
-It is my policy ***not*** to accept social networking invitations from past or current clients using social media sites such as Facebook or other similar sites. This policy protects your confidentiality and also avoids dual relationships, which are harmful to the therapeutic relationship.

Benefits and risks of a mental health evaluation: Usually a mental health evaluation is requested to provide support for a requested procedure. It is possible that a report could support your case, and it is important to me to write a complete and accurate report. Nevertheless, there is not a guarantee that this will be successful. There are also risks to an evaluation – I will ask you to talk about personal and sometimes difficult matters, and this can bring up uncomfortable thoughts or feelings. I always intend for the interview to be as friendly as possible, and it is always permitted to take a break at any time before continuing.

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ACKNOWLEDGMENT OF INFORMED CONSENT

It is important that you understand your rights and responsibilities as a client. Please sign at the bottom of the page to acknowledge that we have discussed these issues.

Confidentiality and Notice of Privacy Practices

I understand my right to confidentiality and the limitations that exist, and I have received a copy of the Notice of Privacy Practices.

Client Rights

I understand my rights while receiving services from Johanna Rayman, LCSW, GCFP.

Risks and benefits of mental health therapy and movement practices

I recognize and understand the possible benefits and risks of a mental health interview and evaluation.

Professional Relationship

I understand the mutual expectations of our professional relationship (office policies).

Payment agreement

☐ *Private/direct payment: I agree to an ongoing fee of $_____ /session.*

☐ *Insurance: I agree to pay a copay of $ _____, or coinsurance of _____%, the remainder to be billed to my insurance company:_____.*
If my insurance does not cover a session (for example if there is a deductible, or if coverage has ended), I understand that I am responsible for the payment of that fee.

☐ *Oregon Health Plan / Crime Victims' Compensation / Care Assist: not required to pay any portion of the fee.*

I understand the payment policy. I understand that a third party payer may request information from my records. I also understand that if I cancel an appointment with less than 24 hours' notice or do not show for an appointment, I will pay the fee of $50 (does not apply to OHP / CVC / Care Assist).

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I have read this document in full, and I have been informed of the procedures and conditions as outlined in this document. I have had an opportunity to discuss these procedures and conditions with my therapist and I am satisfied that my questions have been answered to the extent possible. I accept the help offered with full knowledge and understanding of our professional relationship, policies, my rights, and the Notification of Privacy Practices (HIPAA).

Client Name	Signature	Date

Responsible party (if client is under 18 years of age)	Signature	Date

Johanna Rayman, LCSW, GCFP		
Therapist Name	Signature	Date