

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

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

OFFICE POLICIES

Getting Started: At our first appointment, we will talk about your current concerns, and decide if we can work together to address them. Usually I will do an assessment for a diagnosis, and we can discuss this if you wish. We may need to discuss a referral if you need additional services or if my abilities or style are not a good match for you.

Fees & Insurance: • One-hour session: \$150 • 45-minute session: \$125

• Reduced rate for payment at time of service: \$90-\$125 for a one-hour session. I have a limited number of slots for people who need further discounts. Cash/Check/Credit Card accepted.

• Insurance: Mental health services may be covered in full or in part by your health insurance. I may be able to help you determine what your benefit is. I ask that at each session you pay the amount that you are responsible for (copay, coinsurance, or deductible). If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. In my contract with an insurance agency, I accept their allowed amount as payment in full.

• Testimony fees (conferring with attorneys, reviewing records, travel time, waiting time, testimony time, etc.): \$150 per hour. This service is not covered by insurance but is waived for OHP and CVC.

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**

Ending services: Termination of services may occur at any time and may be initiated by either the client or the therapist. If you decide to end treatment, I ask that you consider coming in for at least one last session and take time to discuss and reflect on the process you have been through.

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.

Mental health therapy – Benefits and risks: Therapy has many potential benefits including better relationships, tools to manage difficult situations, increased ability to tolerate difficult feelings, and increased mind-body connection. However, since therapy often involves discussing unpleasant aspects of your life, you may feel worse at times. Making changes in your life can be scary, and can disrupt your relationships. It is important that you consider whether these risks are worth the benefits to you.

Body-Centered Psychotherapy: Some of the therapy methods I use may include movement or physical contact at times. I find this way of working can be helpful ways for people to connect with themselves, learn self-regulation skills, and process/integrate past experiences – but it can also provoke uncomfortable thoughts or feelings for some people, or even be scary or triggering. In addition, some risk for physical injury is possible with any activity that includes movement or physical contact, although this is not common. This way of working will only be used if/when we both agree that it seems beneficial, including having a conversation about maintaining appropriate boundaries. It's important to note that I never have any sexual contact with any of my clients for any reason. I assume complete responsibility to maintain this boundary. You have the right to refuse any activity that is offered in session, without any impact on the services you receive. Please let me know if you have physical injuries or limitations, or any other concerns about doing body-centered work.

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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 acknowledge and understand the potential benefits and risks of entering a therapy process, and consent to receive mental health services provided by Johanna Rayman, LCSW, GCFP. I am aware of the potential risks and benefits of using movement and touch in therapy, and that I have the right to refuse any kind of touch or movement that is offered in session, without any impact on the services I receive. My questions regarding these risks and benefits have been answered.

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), 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