Pete Morones, Ph.D.
Licensed Psychologist
3310 SE Division St.
Portland, OR 97202
503-236-4665

CONSENT TO TREATMENT & OFFICE POLICIES

Psychological Services: Welcome to my practice. I am an independent licensed psychologist in private practice. Psychotherapy or *"therapy"* is a collaborative process that varies based on the issues that you are facing and the dynamics between the psychologist and client. Therapy calls for an active effort on your part during and in between sessions in order for treatment to be most beneficial. Our first few sessions will involve a review of what led you to seek therapy, learning about your symptoms and your background. You are also welcome to ask me questions. All of this information is helpful in getting to know you and to help us both determine if we are well suited to work together.

Therapy can have benefits and risks. It may provide relief and benefits such as reduction in stress, alleviation or improvement of certain problems, increased confidence and self-esteem. Therapy can also have a positive impact on relationships. However, addressing challenging aspects of life can also evoke uncomfortable feelings and alter interpersonal relationships. These are all normal aspects of the therapy process. While there is no guarantee of what you will experience in therapy, or of the treatment outcome, I will work to foster a supportive, safe, trusting and respectful experience as we work together to address your concerns and goals.

Therapy involves a commitment of time, energy, and financial resources. Evaluate the information provided and consider your impressions to determine if we are a good fit. If at any time you have questions or concerns, please feel free to discuss them with me. I will check with you periodically to see how you are feeling about the therapy process so that we can make changes that support your goals. Also, if you have questions about my practice, policies, procedures, fees, or qualifications, please do not hesitate to ask. Please know that I will be happy to suggest referrals to other mental health professionals or resources if either one of us determines that you are not progressing.

Emergencies: Should you need to contact me between appointments, please call (503) 236-4665 and leave a message. I am NOT able to receive/respond to texts. I typically return calls within 24 hours Monday-Thursday. If you have an emergency that requires immediate attention, please leave me a message, and then call the 24-hour Crisis Line at 988. You can also call 911 or go to your nearest emergency room.

Privacy & Confidentiality: Your work in therapy is private, confidential, and protected by state and federal laws. No identifying information will be released to other parties without your consent, except as necessary, required or permitted by law under the following circumstances:

- If you chose to use insurance, I will need to share information with your insurance company or their representatives. Such information usually includes diagnostic and treatment information. They may also request a more compressive review of your chart that may include psychological, psychiatric, medical, substance use, and other aspects of your personal and interpersonal history. You have the right to not utilize insurance that is explained further in the separate Fee Agreement & Policies document. I will do my best to answer questions regarding insurance, however please keep in mind that I do not work for the insurance companies and I do not know the particulars of your insurance plan or policies. You are advised to check with your insurance regarding questions and concerns about your information and policy.
- Harm or risk of harm to yourself and/or others. Examples include abuse of a minor, older adult, disabled person; imminent risk of hurting yourself, another identified person, or intended acts of violence that may jeopardize the welfare of others or society (i.e., acts of terrorism). Crimes, threats, or violence directed at my property or me.
- Information necessary as part of standard business and practice operations and/or HIPAA (e.g., sharing necessary information with professional assistants, professional consultants, bookkeepers, billing/collection services). I may also need to share information with other mental health professionals providing coverage in my absence.

- Court order/Subpoena. If you are involved or associated in legal proceedings, or the subject of an investigation, and a request is made for information regarding your therapy. Such requests may include information regarding your diagnosis, history, health, medications, use of substances, clinical impressions, observations, recommendations, or disclosures that you have shared during out work together, including relationships. Such information is protected by psychologist-patient privilege law and professional codes of conduct unless you or your representative waives your rights to confidentiality; or if there is an enforceable subpoena or court order.
- Worker's Compensation, disability, life/health insurance or similar claims. If you file such a claim or application, requests are often made for parts or all of your medical records, including psychotherapy records. When you file or apply for such claims you may be asked to waive part or all of your rights of confidentiality.
- If you file a complaint against me, I may disclose the necessary information about you and our work together to comply with an investigation and/or to defend my actions.
- If you grant me explicit permission to share information regarding your treatment with another party.
- Medical emergencies or accidents.

If, or when, I receive a request to disclose information about you and/or your treatment, I will attempt to contact you to discuss options and respect your wishes. Such requests may occur during or after therapy, including several years later. It is strongly advised that you consult with an attorney regarding how such disclosures, waiving of rights, or a request that I do not share your information, may affect you and your case.

To provide a high quality of care, I may exchange information with other professionals to promote your care and well-being. This could include past or present health care providers. Unless there is a critical or emergency situation, I will seek your permission and explain my reasoning. Together we will decide what information may or may not be shared. In addition, to provide a high degree of care, I may occasionally consult with other healthcare professionals regarding your treatment; however, this will be done without disclosing your name or identifying information unless I have your explicit permission to do so. Please do not hesitate to ask questions or discuss your concerns regarding confidentiality.

Additional Policies: 1. If you have or suspect a contagious condition (e.g., COVID, flu, cold) and have a scheduled office appointment, please inform my office to discuss options. 2. Firearms, knives and other items and deterrents designed for protection and/or to cause bodily harm are prohibited in the office or on the property. 3. Smoking/Vaping is not permitted within the office building. Please feel free to discuss any questions or concerns regarding these additional policies.

HIPAA: Included with these forms is information on the Health Portability and Accountability Act (HIPAA). This is a federal law that provides protections and rights with regard to health care information for the propose of treatment, payment, and health care operations. HIPAA requires that I offer you a form titled: *Notice of Privacy Practices* and that I obtain your signature acknowledging that you were offered this information. Please take time to carefully review this separate document.

Acknowledgement: My signature* below acknowledges that I have completely read, understand and accept Dr. Morones' Consent to Treatment & Office Policies. My signature also serves as an acknowledgment that I received or was offered the document ***NOTICE OF PRIVACY PRACTICES (AKA HIPAA)*** document. I've had the opportunity to discuss any questions and/or concerns related to this document with Dr. Morones and/or any other representatives of my choosing permitting me to make an informed decision before signing this consent document.

*Please note that should you decide to utilize electronic signatures for any forms associated with Dr. Morones' practice, such signatures will be considered as valid and legally binding.

_____ _____

CLIENT SIGNATURE OR LEGAL REPRESENTATIVE DATE

1/24

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CLIENT PRINTED NAME