Rose City Psychotherapy
2143 NE Broadway St, #1
Portland, OR 97232
Phone: 503-885-4832 | Fax: 503-749-6264

INFORMED CONSENT AND OFFICE POLICIES

I. Confidentiality

I have an obligation to maintain the privacy of my current and former clients. Whenever possible, disclosure of client information will occur with written informed consent of the client(s) through a release of information process. Exceptions to this responsibility will only occur when there are overriding legal or professional reasons to disclose client information. My mandatory reporting obligations include: the reporting of the abuse or neglect of children or of vulnerable adults; the duty to take steps to protect or warn a third party who may be endangered by the client(s); the duty to protect a client from self-harm; and, the duty to report the prohibited or unprofessional conduct of another licensed professional. Parents with children 14 years of age or older are required to have a signed consent for release of information for any level of communication.

Additional reasons that may require that I release information without your consent include the access of legal guardians to the records of some adults, access by the courts to mandated reports, subpoenas and court orders, and access by third party payers to information for the purpose of treatment authorization or audit. When I disclose confidential client information, I disclose the minimum amount of information needed to accomplish the intended purpose of the use, disclosure or request.

Psychotherapy via telephone or virtually through video conferencing platforms carry the risk of breach of confidentiality if you are in a location where others may be present or can hear your conversation. All digital and internet related services carry the risk of breaching confidentiality via hackers or other cyber threats.

II. Retention of Records

I retain client records for (7) seven years from the date of the last session with the client.

III. My Training and Approach

I hold a master's degree in social work (MSW) earned in 2011 at the University of Southern California. I am a licensed clinical social worker (LCSW #L6258) in the state of Oregon. I offer psychoanalytic psychotherapy, which is largely an insight oriented and explorative approach to therapy. I have training in CBT (cognitive behavioral therapy) and DBT (dialectical behavioral therapy), which may be used throughout the course of therapy. You are free to ask questions about my therapeutic approach and interventions at any time. I will not tell you what to do or give advice because that robs you of the invaluable experience of growth and learning. I do not disclose personal details of my life in order to keep the focus of therapy on you, and to maintain my personal privacy.

IV. Risks and Benefits

There are no miracle cures and I cannot promise your circumstances will change. In some instances, therapy can result in unintended results. Exploring and processing feelings and thoughts may be painful. Change can be scary and sometimes be disruptive to your current relationships and life. You may find your relationship with me to be a source of strong feelings, some painful at times. The

Client Initials: ____

benefits of therapy will vary, but some goals of psychoanalytic psychotherapy are symptom relief, insight, personal agency, a strong and cohesive sense of self, self-esteem, recognizing and handling emotions, to feel pleasure and serenity, and a capacity for love, work, play, and mature dependence. Psychotherapy is a long-term process and requires an ongoing financial and time commitment. Using insurance benefits to help cover the costs of psychotherapy carries certain risks including, but not limited to, less personal privacy due to involvement of a third party in your health record, and the possibility of restriction, denial, or change to your current benefits that could impact your access to psychotherapy.

V. Emergencies

I do not provide 24-hour service and may not be available for immediate response. If you are in need of support and cannot reach me, please call the Multnomah County Crisis Line at 503-988-4888 or toll-free at 800-716-9769. For urgent matters a 24-hour psychiatric emergency department is located at Unity Center for Behavioral Health. The address for Unity is 1225 NE 2nd Ave, Portland, OR 97232 and the phone number is (503) 944-8000.

VI. Appointments, Cancellations, Fees, and Other Policies

a. ***Appointments:*** Sessions are 45 minutes and will start and stop at a mutually agreed upon day and time. The out of pocket fee for a 45-minute session is on a sliding scale $100-$140. The first appointment is an initial consultation with the purpose of helping the client to decide if they feel comfortable and interested in what Mike Mihalas, LCSW offers. Mike Mihalas, LCSW will also decide if he believes he can be of help to the client and feels comfortable with the client-therapist fit.

b. ***Phone, email, and written materials:*** Phone calls, emails, or written materials that exceed 10 minutes of work time are billed prorated from our agreed upon rate. Email and text messaging are convenient but not secure methods of communication. By communicating via email or text message and/or requesting a response from me via email or text message, you are hereby giving your consent for a response by email or text message, understanding that email and text messages may not be encrypted and even if encrypted, email and text messages poses security risks that threaten confidentiality (i.e., other people reading your messages, hacking and email pirating, lost or stolen devices). If you would prefer a response in another format (telephone, voice mail, FAX, or postal service), please let me know. All communications no matter their method of delivery are part of your client record.

c. ***Cancellations:*** 24 hours notice is required when cancelling appointments. Providing less notice will incur a late cancellation fee, which is the amount I am reimbursed by your insurer or our agreed upon out of pocket amount. The exceptions to this policy are: (1) during winter storm events based on the guidance of Portland Public Schools, (2) if you would endanger yourself by attempting to come, or (3) someone whose caregiver you are has fallen ill suddenly. I reserve the right to terminate our work together and refer you to an alternate provider if there are frequent cancellations/reschedules/no shows (3 or more times in a 2-month period). I reserve the right to terminate our work together and refer you to an alternate provider if I believe I am unable to help you or meet your needs in therapy. You are free to leave therapy at any time without financial or legal obligations other than those you have already incurred.

Client Initials: ____

d. **Audio recording for professional development:** For the purposes of professional growth and continuing education, I may elect to audio record sessions on a device not connected to the internet. Recordings will be destroyed within 7 days. No extra information other than what was discussed in the session will be included.
e. ***Paper copies:*** Charges for file copying include a $60 per hour fee for preparing and copying the file, $0.25 per page, and the postage fee required to ship to the designated address. I may require payment in advance.
f. ***If legal involvement is required:*** If I am required to appear in court or for a deposition, you agree that my hourly rate is $300 for preparing reports, testifying, being in attendance, and any other case-related costs.
g. ***Emotional Support Animal Letters*****:** I do not write letters for emotional support animals and suggest a company such as CertaPet (certapet.com) or other similar companies.
h. ***Unpaid accounts:*** I have the option of hiring a collection agency or going through small claims court to recoup unpaid fees after 30 days of an unpaid balance. If such action is necessary, its costs will be included in the claim.

Consent to Psychotherapy

I read the above document and had the opportunity to ask questions and discuss my concerns to my satisfaction. I agree to undertake therapy with Mike Mihalas, LCSW. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Mr. Mihalas. I hereby consent to treatment and agree with all provisions contained herein.

_____ _____
Date **Client** Signature

_____
Client Printed Name

_____ _____
Date **Parent** Signature

_____
Parent Printed Name

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Consent for Insurance Billing

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to Michael Mihalas, LCSW.

_____ _____

Date **Client** Signature

_____

Client Printed Name

_____ _____

Date **Parent** Signature

_____

Parent Printed Name

Client Initials: ____