Lysa Webb, MA LPC
5319 SW Westgate Drive Suite #211-A
Portland, Oregon 97221
503-515-2940

Informed Consent to Treatment

I am willfully agreeing to enter into treatment to be provided by Lysa Webb, MA LPC. I have been informed of the nature and expected course of treatment and of possible limitations. I also agree to the billing policy set forth while in treatment with Lysa Webb, MA LPC. I understand that I will be informed of any change in treatment and that I may revoke consent at any time without reprisal.

I have been informed of my right to a confidential relationship within specified limits. I understand that information given in the context of treatment will not be shared with others without my written permission except in cases of abuse or potential danger to myself or others. These may include any statements I make of intent to commit suicide or homicide, statements indicating that I have committed, or intend to commit, acts of child or elder abuse, or in the case of a medical or other emergency which would necessitate disclosure of relevant information to facilitate further treatment. I also understand that pertinent information may be disclosed for the purposes of third-party billing and for collecting past due fees (i.e. through a collection agency). In the latter case, this action will be taken only after I have received a written warning.

My signature below means I have read the above statement and understand and agree to enter into treatment/assessment under these conditions. Further, it indicates that I have had the opportunity to ask questions about the policies and HIPAA privacy notice, and have had those questions answered to my satisfaction.

I may revoke this agreement in writing at any time. Above therapist will need to accept that revocation except for: 1) actions that I have already taken on the agreement before it was revoked; 2) if any financial obligations have not been satisfied; or 3) if there are obligations imposed on above therapist by my health insurer in order to process or substantiate claims.

__ I want a copy of the HIPAA statement.
__ I do not want a copy of the HIPAA statement.

_____
Client's Name (please print)

_____
Client's (or legal guardians') signature Date

_____
Lysa Webb, MA LPC Date