Disclosure Statement & Agreement For Services
Tracy Wikander, MFT
License CA: #49104
License OR: #T1144

Consent to Treatment
The majority of people who participate in counseling benefit from the counseling process. Like most kinds of healthcare, this kind of process requires a very active effort on the individual's part. In addition, there may be certain kinds of risks involved. For example, the counseling process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks.

Fees and Insurance
The fee for service is $ 100 per 50-minute therapy session. I offer a sliding scale for those individual and families in financial need. Fees are payable at the time that services are rendered.

I am dually licensed, in the State of California and Oregon, thus am able to legally practice in both states. I practice in California via telemedicine, by phone and/or Skype. California insurance plans will not cover sessions via telemedicine from Oregon even though I am licensed in California.

I accept Visa, MC, and Discover.

Confidentiality
All communications between you and I will be held in strict confidence unless you provide written permission to release information about your counseling process.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

If you participate in marital or family therapy, I will not disclose confidential information about your counseling process unless all person(s) who participated in the counseling process with you provide their written authorization to release such information. **However, it is important that you know that I utilize a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or couples therapy, and I see a smaller part of the treatment unit (i.e. an individual or two siblings) I am permitted to use information obtained in that session when working with other members of your family. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually. Please feel free to ask me about this "no secrets" policy and how it may apply to you.

Minors and Confidentiality
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's counseling are often involved in their counseling process. Consequently, as your therapist, and in exercising my professional judgment, I may discuss the counseling process progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Appointment Scheduling and Cancellation Policies by phone
I will make every effort to accommodate your scheduling needs. In return I ask that you keep your scheduled appointments and notify me in advance if you are unable to do so. With advance notice I am often able to accommodate other clients that are waiting to book an appointment. **Please notify me if you must miss an appointment 24 hours in advance of your appointment. If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please contact me via phone for last minute changes for scheduling, not email.**

In the event that I am unable to give a 24 hr. notice of cancellation, I understand that my credit card below will be charged the amount of the session.

Credit Card #: _____Exp. Date_____

Name on Card:_____

Address: _____, State:_____, Zip code:_____

Telemedicine

Telemedicine is engaging in psychotherapy via the phone or audio/video program, such as Skype. I understand that there are possible risks and consequences from telemedicine, including but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that; the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions.

I am generally available to return phone calls within approximately 24 hours, between the hours of 9am and 4pm. I am not available to return calls on Saturdays, Sundays, or Holidays.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask me to address any questions or concerns that you have about this information before you sign.

Client Signature:_____Date:_____

Client Signature:_____Date:_____

By signing this agreement, I acknowledge that the client is a minor, and I am the parent or legal guardian, and I have read this agreement, understood its terms, agree to be subject to its provisions, and voluntarily agree to the minor's participation in the treatment.

Parent Signature:_____Date:_____
*Required if client is under 18 yrs. old

Parent Signature:_____Date:_____
*Required if client is under 18 yrs. old