James M. Mours, L.L.C.

INFORMED CONSENT FOR TREATMENT AND EVALUATION

Dr. Mours would like to inform you of your rights and responsibilities while utilizing his services.

1. You have **the right to be informed regarding the terms under which treatment or evaluations will be provided**. Our policies related to charges, billing, third party payors, appointments, emergencies, and coverage for when your therapist is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. You have **the right to choose the best treatment and provider.** There are a variety of professionals in the community offering counseling, psychotherapy, medication management, and psychiatric evaluations. There are also a number of different approaches to working with clients and their issues. It is your right and responsibility to choose the treatment and provider that best matches your needs and to participate in the development and regular review of your individualized treatment plan. You also have a right to a detailed explanation of any treatment or procedure your provider may choose to use including the risks involved and the potential side-effects, if any. If you believe you are not receiving the treatment you require, then raise this concern with your therapist or provider and they will work with you to revise your treatment plan or refer you to other professionals who may be able to meet your needs.
3. You have **the right to know the qualifications and training of your provider**. You may request a curriculum vitae which lists the education, training and qualifications of your provider. You may also seek information from the Oregon Board of Psychologist Examiners with regard to Dr. Mours's qualifications.
4. You have **the right to refuse treatment or to stop treatment at any time and for any reason**. In the case where a minor is the client, then the parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop an evaluation. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. It is our hope that if you have concerns regarding your treatment or wish to discontinue you will discuss this with your provider.
5. You have **the right to your diagnosis.** This means that after your initial mental health assessment, the treatment provider will provide you with their initial diagnosis or provisional diagnosis.
6. You have the **right to confidentiality**. This means that what you tell your therapist or provider and what is contained in your clinical file will not be repeated or released by the therapist to anyone else without your expressed permission (i.e. by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy or evaluation with anyone you choose,

including another provider. The content within group therapy is confidential and may not be shared with anyone outside of the group.

7. For minors 14-17 years old you have the **right to initiate your own treatment**. Oregon law requires your therapist to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. Dr. Mours does not need to involve your parents in treatment if you have been sexually abused by your parent, or if you are emancipated. It is the policy of Dr. Mours to notify the parents on or before the third (3) session of therapy.

By signing this informed consent document you:

I. Authorizes Dr. Mours to contact your parents and to give them a summary of your treatment.
II. Authorize your therapist to use their best clinical judgment on when to inform your parents of important issues related to your treatment.
III. Authorize Dr. Mours to release your treatment records to your parents upon their request (it is the policy of Dr. Mours to require both you and your parents to sign any release of information to anyone other than your parents)

There are, however, some limits and exceptions to complete confidentiality:

1. CHILD OR ELDER ABUSE: Generally, providers are required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or other appropriate state agency.
2. VIOLENCE: If a provider learns that someone is about to kill or to do harm to someone else, they will do their best to warn the intended victim.
3. SUICIDE: If a provider learns that a client intends to harm their self, the provider will breach confidentiality to the extent necessary for their protection.
4. NON-CUSTODIAL PARENTS: By law, non-custodial parents can gain access to their children's records pertaining to treatment or evaluations.
5. SUPERVISON: If you are seeing an unlicensed therapist (e.g., a master's level counselor, psychology intern, or a psychologist resident, etc.) then it is expected that your therapist will initially present your case in a clinical staffing and also periodically review and discuss your treatment with a supervisor. You will be informed as to who the supervisor is prior to receiving treatment or evaluation.
6. CONSULTATION: Occasionally, it is in your best interest for your provider to consult other providers within the community regarding your treatment (e.g., medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). This will be carried out with the utmost consideration for your privacy. In cases where consultation with another professional is required, then your written consent will be obtained.
7. INSURANCE: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.

I have read and understand my rights and responsibilities as outlined in the James M. Mours, LLC, informed consent for treatment and evaluation form. Furthermore, by signing this form, I consent to receive Mental Health Services provided by Dr. James Mours.

Signed: _____ Date: _____
Client Signature

Signed: _____ Date: _____
Parent/Guardian Signature