Denise J. Hockley MS, LMFT
OR License # T1513 CA License # LMFT30255

LICENSED MARRIAGE
& FAMILY THERAPIST

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PROFESSIONAL DISCLOSURE STATEMENT

WELCOME TO MY PRACTICE!

This document contains important information about my professional and business policies and how they may affect you. Please read them carefully and make a note about any questions you may have so that we can discuss them at the first session. Once you sign this agreement it becomes a binding agreement between us and also signifies your consent for us to begin therapy.

PHILOSOPHY AND APPROACH

Our therapeutic relationship is entirely voluntary. Therapy is a process during which you and I will discuss a variety of issues, events, experiences and memories for the purpose of creating positive change. It provides an opportunity to better and more deeply understand yourself, as well as, any concerns you may be experiencing. Progress may vary depending upon both the presenting problem and your motivation.

I believe that every individual can improve their current circumstances by learning new coping skills. I use an eclectic approach, providing compassion and understanding along with cognitive behavioral therapy and mindfulness tools.

MY BACKGROUND AND QUALIFICATIONS

The name of my practice is Denise Hockley Counseling and I received my MS in Counseling Education from San Diego State University. I received a Bachelor's of Arts in Social Ecology in 1981 which had an emphasis in Counseling. I was licensed as a Licensed Marriage and Family Therapist on 12-11-1992 by the Board of Behavioral Science Examiners in California. My California License number is LMFT 30255. I was licensed by the Board of Licensed Professional Counselors and Therapists in Oregon on January 18, 2019. I am a Clinical Member of the California Association of Marriage and Family Therapists in good standing.

REQUIREMENTS OF A LICENSEE

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license, I am required to participate in continuing education, taking classes dealing with subjects germane to improving and maintaining my psychotherapy skills.

FEES AND INSURANCE

The fee for service is $ 150.00 per individual initial session.
The fee for service is $ 125.00 per individual regular therapy session.
The fee for service is $ 175.00 per conjoint (marital/family) for an initial session.
The fee for service is $ 155.00 per conjoint (marital/family) for regular therapy sessions.
My private Outpatient Alcohol Treatment is $225.00 a session or $2700.00 for a 12-week series.
My other negotiated rate is on a sliding scale with the lowest rate being $75.00 for those in need. Your copay from your insurance company or our agreed upon rate is $_____.

CONFIDENTIALITY

During the course of treatment, all communications between you and me will be held in strict confidence unless you provide written permission to release such information. **Your information is confidential unless during diagnosis, evaluation or treatment, I find that there is a clear and immediate danger to others or to society at which point the information may be reported to the appropriate authority. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse and if**

you make a serious threat of violence towards a reasonably identifiable victim. If I believe you represent a danger to yourself, although I am not required by law to break confidentiality, I am permitted to do so to ensure your safety. I may consult with other therapists to provide the best possible care and will do my best not to reveal individually identifiable information about you. The therapists I consult with are also bound to protect any identifiable information. A court order, issued by a judge, may require me to release information contained in records and/or require me to testify in a court hearing.

CANCELLATION AND RESCHEDULING

In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours prior to the appointment. If you do not provide me with at least 24 hours' notice in advance, you will be responsible for payment for the missed or canceled session. Please understand that your insurance company will not pay for missed or canceled sessions. The no-show or late cancellation fee is **$55.00**. The credit card I have on file from you will be charged for any no-show or late cancellation fees.

EMAIL AND TEXTING

I will email and text with you but not information that is confidential. I have a secure email through Therapy Appointment that will protect your Personal Health Information. Texting is a risk to the secure transmission of personal information. I also do not respond to social media requests.

RECORDS

I take notes during session and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are my sole property. I will not alter my normal record keeping process at your request. Should you request a copy of my records, such a request must be made in writing. I reserve the right to provide you with a treatment summary in lieu of actual records. Records will be destroyed, preserving confidentiality, seven years after termination of therapy.

THERAPIST AVAILABILITY

My office is equipped with a confidential voice mail system that allows you to leave a message at any time. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. **In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 or the Washington County Crisis Line at (503) 291-9111 to request emergency assistance.**

CLIENT LITIGATION

I will not voluntarily participate in any litigation, or custody dispute in which you, your representative and another individual, or entity, are parties. I have a strict policy of not communicating with your attorney and I will generally not write or sign letters, reports, declarations, or affidavits to be used in in regard to your legal matter. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate of $125.00 for individuals or $155.00 for couples and families.

POLICY REGARDING CONSENT FOR THE TREATMENT OF A MINOR CHILD

I generally require the consent of **both parents** prior to providing any services to a minor child. If any question exists regarding the authority a Representative to give consent for psychotherapy, I will require that the Parent(s) or Guardian(s) submit supporting legal documentation, such as a custody order, **prior** to the commencement of services.

RECEIPT OF PRIVACY PRACTICES (HIPAA) FORM

Please initial if you have received a copy of the Health Insurance Portability and Accountability Act Form. It is always available on my website at www.denisehockley.com. _____

CLIENT BILL OF RIGHTS

As a client of an Oregon licensee, you have the following rights:

- To expect that a licensee has met the qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials and a license;
- To obtain the Code of Ethics (Oregon Administrative Rules 833-100);
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be assured of privacy and confidentiality while receiving services as defined by rule or law, with the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to you or others; 3) Reporting information required in court proceedings or by your insurance company or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by you against me;
- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status or socioeconomic status.

You may contact the Board of Licensed Professional Counselors and Therapists **at 3218 Pringle Rd SE, #120, Salem OR 97302-6312 Telephone: (503) 378-5499.Email: lpct.board@mhra.oregon.gov Website: www.oregon.gov/OBLPCT.** Additional information about this therapist is available on the Board's website.

ACKNOWLEDGEMENT

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with me and have had any questions answered to your satisfaction. You agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with me. Moreover, you, as the Client or Representative agree to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Client Name (please print) Signature Date

_____

Client Name #2 (please print) Signature Date

_____ _____

Signature of Child Date

_____ _____

Signature of Therapist Date