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**Informed Consent & Disclosure Form**

The following information is provided to help you determine if what I offer as a mental
health professional meets your needs as a client. This document contains important
information about my background and training, my therapeutic approach, my fees, your
rights regarding your private health information and the limits surrounding that. Please
read this document carefully and ask any questions that help you fully understand the
contents of this disclosure statement and agreement for services.

**License, Credentials & Experience & Therapeutic Approach**

I am a Licensed Professional Counselor Associate with the State of Oregon (A- 6808). I received my Bachelor’s Degree in Education and Family Human Services from the University of Oregon. Also, I have my Master’s in Clinical Mental Health Counseling. I am dedicated to providing services with a commitment to the holistic health of the client. I also believe that everyone can reach an optimum state of health. In comparison, many techniques used in my counseling practice stem from a Cognitive Behavioral philosophy, Family Systems, and Attachment-Based theory and Trauma Focus Therapy. I truly believe that experiences can shape our lives much more profoundly than purely intellectual endeavors. Our lives consist of physical, emotional, intellectual, social, and spiritual components. I believe in all these aspects of human experience to help you achieve your goals. My experience has been focused on trauma, complex trauma, mental health issues with children, early childhood, and adolescence. Drawing from aspects of interpersonal neurobiology I endeavor to maintain a safe, trusting, and accurately attuned relationship with each client. I draw from a cognitive, relational, psychodynamic, family systems, and attachment-based theory that is tailored collaboratively to individual or family therapy needs.  I have worked in the counseling field since 2019 while I was working on earning my degree. I am working with individual, and family and group settings of different ages. Over the years, I had been trained by PMTO (Generation PMTO evidence-based parenting program), PCIT (Parent-Child Interaction Therapy) CPP (Child- Parent Psychotherapy) and TF-CBT (Trauma-focused cognitive behavioral therapy).

**Confidentiality**

Your participation in therapy, the content of our sessions and any information you provide

to me during our sessions is protected by legal confidentiality. In accordance with Oregon and Federal rules and law, including ORS 107.154, 179.505, 179.507, 192.515, 192.507, 414.679 and 42 CFR Part 2 and 45 CFR Part 205.50. Exceptions to this are stated below under Limitations of Confidentiality section.

**Limitations of Confidentiality**

Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

* The receipt of information that suggests that there has been abuse or neglect of a child, elder or adult with a mental illness or disability. This includes a requirement to report intimate partner violence, sexual assault of an adult, and violence witnessed by a child under 18.
* The threat of harm to self or others. This may include warning a person threatened with harm, or disclosure of necessary health information to a person, agency or authority, who has the capacity to deal with the danger (law enforcement, hospitals, protective service agencies).
* My information may be reviewed by my health plan, and if I am covered by OHP/Oregon Health Plan and Medicaid this may be including the Oregon Health Authority or the local coordinated care organization for authorizing services. My information may also be reviewed for quality improvement, utilization management, and site review. With release of information or for coordination of treatment within a CCO (Community Care Organization) individuals providing physical health care may also review my information.
* In the event of a medical emergency, I may release information. This is limited to that which is judged necessary to resolve the emergency and assist in my care by the attending emergency worker.
* In case of psychiatric hospitalization, information about my mental health status prior to entering the hospital, and information judged to be helpful in planning for my discharge from the hospital, may be released.
* Information may be released upon valid court order.
* If I file a legal claim or formal complaint or action against to me, relating to services received.

By initialing you agree that you have read and understand this section

**Mandated Reporting**

As a mandated reporter, I am required by law to disclose certain confidential information

including suspected abuse or neglect of children and suspected abuse or neglect of vulnerable adults, or as otherwise required in proceedings. If you have any questions regarding your confidentiality, the limits of confidentiality, or the exceptions to confidentiality, please let me know. I will be happy to discuss this with you further.

By initialing you agree that you have read and understand this section:

**Family, Couples and Group Therapy**

If you are seeking family, couples or group therapy it is important to understand that I will

adhere to the ethical and legal requirements of confidentiality as stated above. However, I

cannot ensure that you or the other participants will maintain confidentiality about your

therapeutic experience including content discussed within the therapy session. In addition,

during family & couples therapy the entire treatment record will be available to any and all

participants and all participants must consent to any authorized third-party disclosure.

Specifically, for families and couples I do not maintain individual confidentiality—this

means that one person cannot ask for me to withhold certain information they have

disclosed to me from the other member(s).

There are times in individual therapy where you may want, or I may encourage, that

another person joins our session. This can be beneficial for a variety of reasons. Additional

participants in individual therapy are considered collateral contacts. Their purpose during

the session is to help you meet your goals. During these types of sessions, I continue to

maintain your confidentiality and I do not disclose any information from our previous

sessions together, however you may feel free to disclose any information from previous

sessions you see relevant.

By initialing you agree that you have read and understand this section:

**Therapy with Children**

If you are seeking therapy for your child(ren) it’s important that you know the legal

guidelines of confidentiality as it applies to them and to you as their parent. As the parent

of a child under the age of 13 you have the right to participate in therapy, inquire about

therapy session content and request a copy of their session records. However, in order for

me to build a therapeutic relationship with your child they must be able to view our

sessions as a safe space where they can share private things and know that I will not

immediately report everything they have said to their parent. This means that unless there

is a safety concern, I will not regularly share the content of our sessions with you. In order

to gain and maintain trust with my young client, I share with them any conversation that I

have had with their parent regarding them, unless I believe it is developmentally

inappropriate or would be detrimental to their emotional health.

If you are the parent or guardian of a child client, you are to understand that your child is the client. You are also to understand that you are an important part of his/hers/theirs treatment and you will be participating in that process.

 By initialing you agree that you have read and understand this section:

**Children 14-17**

In accordance with Oregon State Law minors who are 14 years of age or older may

receive outpatient mental health treatment without the consent of a parent or guardian. Since they are the one who are consenting to treatment, they alone are responsible (and must) sign this Informed Consent & Disclosure Form & any other applicable paperwork pertaining to their treatment. In order for me to release any information regarding their treatment I must get written permission from them. It is also up to them whether their parent participates in the treatment process and I will respect and abide by the decisions they make regarding that. With that being said, I encourage all children, regardless of their age, to allow their parents/guardians to participate in their treatment process. As a parent, your involvement increases the likelihood of change and healing in their life.

If you are the parent or guardian of a child client, you are to understand that your child is the client. You are also to understand that you are an important part of his/hers/theirs treatment and will be participating in that process.

 By initialing you agree that you have read and understand this section:

If you are between the ages of 14-17, you are understanding that you have the right to start mental health treatment without consent from you parent or guardian. You understand that Oregon law requires that your parent or guardian is involved before the end of treatment unless they refuse or there is a safety reason or concern that they should not be involved. This reason will then be documented in your record.

By initialing you agree that you have read and understand this section:

**Legal Guardianship/Custody**

Be Well Family Counseling adheres to Oregon law which permits all parents or legal guardians the right to inspect, consult, and authorize emergency medical and mental health care (ORS 107.154). Any adjustments to this policy including restrictions on medical decision making, allowances or restrictions for contact between a parent and minor child, court orders for counseling, and/or any other legal documentation related to the medical care of the child must be provided in writing and a copy held in the mental health record. Be Well Family Counseling will request any such records at the initiation of services. It is the parent and/or legal guardian’s responsibility to ensure that they are acting within their rights or informing the treatment team if changes occur within the course of treatment.

By initialing you agree that you have read and understand this section:

**Benefits & Risks of Treatment**

Engaging in therapy can be an emotionally grueling process. You will be put in a position to

examine areas of your life that may be difficult to think about. There are times when you

will leave our session and feel refreshed and confident but there are other times when you

may leave feeling distressed and overwhelmed. This is a normal part of the therapy process

and it’s usually an indication that there are emotional shifts taking place. I encourage my

clients to embrace these difficult times and allow themselves to feel encourage that change

is taking place. Therapy requires work; during the time you spend in session, but also, and

maybe more importantly, the time you spend in between sessions. While I cannot

guarantee that therapy will for certain change any outcome in your life, if you are

committed to the work, good things can come from the time we spend together.

By initialing you agree that you have read and understand this section:

**Consultation**

In order to assure that I am providing my clients with the care that meets the standards of

my profession I seek ongoing consultation from other licensed mental health professionals.

I find this process to be critical in ensuring that I am continually growing and learning as a

mental health provider. It’s important to know that during consultation I may disclose

information about our sessions together, in which case I will withhold your name and limit

the information I disclose to the minimum necessary.

By initialing you agree that you have read and understand this section:

**Telehealth/Telemedicine Consent**

If you and/or your family decided to want to receive mental health services by telehealth, via electronic means through interactive videoconferencing equipment and/or telephone. You are acknowledged that your participation in telehealth is voluntary, and you understand that you have the right to refuse or stop treatment via telehealth at any time. The risks associated with telehealth may include disruption of transmission due to technology failures, interruption and/or breaches of confidentiality by unauthorized persons. I will be providing telehealth services from a confidential environment. You understand that it is your responsibility to maintain privacy on your (the client) end of communication. However, services provided where the client appears to be in a non-private or public location in which the provider believes may be detrimental to the therapeutic process may be prematurely ended and rescheduled for another time. Additionally, clients requesting services outside of Oregon may be limited to the licensing requirements of their clinician.

There will be no recording of any telehealth sessions by yourself or me (Be Well Family Counseling) unless prior written consent is obtained in advance.

By initialing you agree that you have read and understand this section:

**Fee Structure & 24 hours Cancellation Policy**

My fee for a 45-minute therapy session is $80 and 60 mins for $100. I do offer a sliding scale for those individuals that may need it. Payment is due at the time of service. In order to meet treatment goals, it is important to attend all scheduled sessions. Occasionally, it is difficult to attend a scheduled appointment. If you are unable to keep your appointment, you must give me 24 hours advance notice or you will be charged for the session (illness & emergency are an exception).

By initialing you agree that you have read and understand this section:

**Documentation Fees**

There may be instances where you may ask me or I may need to submit documents on your

behalf. An example of this is if a client is filing a disability claim with their place of

employment and needs me to document their mental health treatment. Another example

may be if I am filling out a progress report for court proceedings. If such events should

occur, please know that I may need to charge you for any excessive amount of time I am

spending on these documents. Generally, charges will be based on my hourly fee. I will

discuss this with you as it comes up.

By initialing you agree that you have read and understand this section:

**Electronic Communication & Social Media Policy**

In regular conduct of my practice I use a cellular phone to communicate with my clients for

the purpose of scheduling or cancelling appointments. There may be times when we

communicate via phone regarding therapeutic issues. I try to keep these conversations

brief with the goal that any outstanding concerns should be addressed in the therapy room,

which can be more appropriate and beneficial. Additionally, I also try to limit email and/or

text messages for scheduling or cancelling appointments only. If you need to communicate

with me via email or text for any other purpose, please discuss that with me in person.

In order to maintain the anonymity of our therapeutic relationship I will never

acknowledge our relationship in any capacity outside of the therapeutic environment. This

also pertains to the online environment, meaning, I do not connect with any of my past,

future or current clients on any social media outlet such as Facebook, Instagram or LinkedIn. This falls in line with your confidentiality rights regarding the therapist-client relationship.

By initialing you agree that you have read and understand this section:

**Emergency Calls If there is an extreme life-threatening emergency, call 911 or go to the emergency room of the nearest hospital. The following numbers may also be helpful: • Crisis Hotline: 1-541-689-4000 • Suicide Hotline: 1-800-273-8255**

**Responsibility for Treatment**: As with any other procedure, psychotherapy involves some risks. Whenever you make significant changes in your lifestyle, outlook or habits, your life and the lives of those with whom you are closely involved will be affected. While the purpose of psychotherapy is to make changes, you will want to consider the consequences that might arise. Whatever changes you make will be both your choice and your responsibility. If you become concerned about the course of your therapy, please let me know so that you can have the course of treatment best for you.

By initialing you agree that you have read and understand this section:

**Individual 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 of a licensee;
* To obtain a copy of 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.
* Have all services explained, including expected outcomes and possible risks;
* Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;
* Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances.
1. Under age 18 and lawfully married;
2. Age 16 or older and legally emancipated by the court; or
3. Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.
* Inspect their service record in accordance with ORS 179.505
* Refuse participation in experimentation;
* Receive medication specific to the individual’s diagnosed clinical needs, including medications used to treat opioid dependence
* Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety
* Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation
* Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
* Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
* Exercise all rights described in this rule without any form of reprisal or punishment.

By initialing you agree that you have read and understand this section:

**Complaints and Grievances:**

 I make every effort to provide services that are pleasing to you. If you believe I have failed to provide satisfactory care or have acted unprofessionally or unethically, please let me know, so I am able to correct this.

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@oregon.gov Website:** [**www.oregon.gov/OBLPCT**](http://www.oregon.gov/OBLPCT) **For additional information about this intern, consult the Board’s website.**

By signing this document, you are attesting that you have received, read, fully understood

and consent to the disclosures, terms and conditions above and have been given the

opportunity to ask questions.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_