995 Willagellespie Road, Suite 100
Eugene, OR 97401-2186
Phone 541-246-7263
Fax 541-343-7360

Jenny Mauro, Ph.D. LLC
Psychologist
Informed Consent Statement

Please read the following information carefully and let me know if there is any part that you do not understand.

Treatment:
Counseling and consultation are a joint effort on the part of the psychologist, patient, and participating family members. Your active participation is a key factor for successful outcome. We will begin with an evaluation of needs for you and/or your child, and work together to create a plan for treatment based on your needs and goals.

Therapy frequently leads to reductions in feelings of distress. However, since therapy often involves discussing difficult events and feelings, occasionally you or your child may go through periods of time when symptoms appear to worsen. These difficulties typically subside as our work together progresses. It is important that you discuss any behavior changes, needs, requests, concerns, or questions that may arise throughout the therapeutic process. You have the right to request changes in the treatment or to end treatment at any time.

Communication:
All communication is completed by telephone. If I am unable to reach you, I may leave messages regarding scheduling or other matters, so please be sure to listen to all messages before calling me back.

I am available until 5pm on most office days by calling my office number for brief phone calls. If I am unavailable at the time you call, please leave a message informing me of some times when you will be available, and always leave your phone number. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. When on vacation or otherwise unavailable for extended periods of time, I will provide referral information for another behavioral health provider.

Emergency Coverage:
If you need immediate assistance or emergency care, please call 911 or local 24 hour crisis lines: Whitebird at 541-687-4000, Sexual Assault Support Services at 541-343-7277. You may also walk into your local Emergency Room or Urgent Care Center.

Limits of Confidentiality:
A detailed description of the limits of confidentiality is provided in the "Notice of Privacy Practices." Please read this notice carefully and ask me if you have any questions or concerns.

Thrive Behavioral Health is associated with Eugene Pediatric Associates (EPA), and uses EPA's Electronic Medical Record system to facilitate each appointment, write orders, review labs, and view patient records. Therapy notes reflecting the content of therapy sessions will be locked to prevent access by users outside of Thrive Behavioral Health. Secure systems are used to protect information and prevent unauthorized access. All healthcare providers utilizing this system must agree to follow written policies controlling access to information. In addition, technical safeguards include encryption, password protection and the ability to audit and track each viewer's usage of the system.

Thrive
Behavioral Health

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Fees and Appointments:
Fees vary by the service provided. You are responsible for your balance. It is your responsibility to monitor the status of your insurance benefits. It is also your responsibility to inform me of any changes in your insurance coverage. You are responsible for any and all costs not covered by your insurance company. We will not file appeals on your behalf to your insurance company. You are responsible for any charges for which your insurance or other payment source does not pay within 60 days of receiving service. If your balance is not paid within 60 days, you may be forwarded to a collection agency. Fees and insurance co-pays are due at each session unless other arrangements are made with me in advance. If you have an unmet deductible, the session must be paid for at the time of service.

*Cancellations must be made at least 24 hours in advance of the appointment time.

I have read, fully understand, and agree to the conditions for treatment described in this statement. I also understand that I can withdraw from therapy at any time.

Client's Name (Print) _____

Client's Signature _____Date_____