

Megan Ogle, Psy.D.

Licensed Clinical Psychologist

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Informed Consent to Treatment

I am a licensed psychologist in Oregon (#2237). I provide psychotherapy to individuals ages 18 and older. I also provide psychological and developmental assessment to individuals of all ages. I received a doctorate in clinical psychology from Rosemead School of Psychology in 2011. I completed my internship and post-doctoral residency at Portland State University's Center for Student Health & Counseling in 2011 and 2012. I have been performing clinical work since 2006.

It is important to note that psychotherapy can have benefits as well as risks. Potential risks could include unpleasant feelings such as guilt, sadness, anger, anxiety, and/or disappointment amongst others. Even though these risks are possible and psychotherapy can be challenging, it has been demonstrated through research that psychotherapy is beneficial for most people. At the onset of therapy we will discuss goals for therapy and a treatment plan. If I determine at any time that we are not a good fit or that you need services that I cannot provide, I will give you recommendations. If you have questions for me about my approach to therapy, please ask them at any time.

Philosophy and Approach: The goal of psychotherapy is to provide a collaborative relationship to help you with issues you are dealing with and provide treatment options and planning to help you succeed. The techniques used are generally best practices that are supported by the psychotherapy and therapeutic community in addition to being supported by current research. I generally work from a contemporary relational psychoanalytic perspective, applied with clinical judgment based on the needs of the client. This means that a part of the therapeutic process will include talking about our therapeutic relationship, as this often consolidates the client's sense of how change is occurring through psychotherapy.

Formal Training and Education: BA Psychology, University of San Francisco, 2005; MA Clinical Psychology, Rosemead School of Psychology, 2007 and PsyD Clinical Psychology, 2011. Major coursework included, but was not limited to: diagnosis and treatment planning, intellectual, objective, and projective assessment, statistics and research

methods, ethics, human growth and development, clinical and psychotherapy skills, group therapy, and human diversity. My training included clinical treatment in the following settings: university counseling/community mental health center, elementary school, adult inpatient hospital, pediatric hospital. I am registered as a Licensed Psychologist with the Oregon Board of Psychologist Examiners, and my work abides by its Code of Ethics.

Fees: Payment for psychotherapy services are listed below:

50 Minute Individual Session (Sliding Scale Available) \$140.00

*Phone calls after initiation of treatment that are longer than 5 minutes will be charged \$50.00.

Full-length phone sessions are not customary, but are arranged under extenuating circumstances.

In this case, a phone session accrues the full session fee of \$140.00.

I have a sliding fee scale for those who qualify. Any agreements made regarding payment will be made within already established sliding fee scale for the number of clients designated to receive discounted services. Payment agreements will be designated and kept on file. Payment agreements may be revisited on a quarterly basis to determine further qualification and eligibility. The designated fee will also be charged for additional services provided at your request or for Megan Ogle, Psy.D., for your benefit such as report writing, psychological test administration and scoring, reviewing records from other professionals, consultation with other professionals, hospital visits, and phone calls lasting longer than 5 minutes with you or others.

Insurance: I am an OUT-OF-NETWORK provider for insurance companies. If you want to use your insurance plan, please let me know. I work with a billing service which will help you to confirm your insurance benefits. This billing service will receive limited information pertaining to your case—only information necessary for insurance billing will be disclosed, within HIPPA compliance. Please remember that your insurance contract is between you and the insurance company. You are ultimately responsible for paying the fees that we have agreed upon if your insurance company does not pay for some reason. Co-pay is always due at the time of your appointment.

Scheduling & Cancellation Policy: Most appointments last 50 minutes. During an established treatment, a client reserves one or more of my appointment hours per week. If you are late I will have to still end on time in order to maintain my schedule for other clients. I charge \$100.00 for sessions you miss or cancel following our agreed-upon scheduling. The late cancellation fee will not be charged if the session is successfully rescheduled within the same business week. If you miss an appointment, your insurance company will not cover the \$100.00 fee.

Emergencies: You may reach me between appointments during the day by leaving a message on my voicemail. I will call you back as soon as possible. If you leave me a message after business hours, I cannot guarantee I will get back to you until the following day. Please note, if you are in crisis and need emergency/ immediate support, call the Multnomah County Crisis Line at 503-988-4888. In emergencies when you believe you are a risk to your own or to someone else's safety, please call 911 or go to the nearest emergency room or hospital.

Diagnoses, Tests, and Written Reports: You have the ability to review and discuss your records, treatment, and treatment planning. You have the right to know what treatment techniques and methods are used and why. These are to be used solely to assist in your education about any diagnoses and the treatment of your condition. Any diagnoses, tests, or reports are strictly confidential and cannot be released without your written approval unless there are circumstances related to limitations listed below.

Confidentiality Rights and Limitations: While most matters discussed during treatment are kept strictly confidential, there are limitations that must be addressed at the time of consent. If at any time during treatment you disclose the abuse or neglect of a child, an elderly person, a disabled person, or an animal or disclose the intent to seriously harm yourself or others, I am legally and ethically obligated to immediately report it to the proper authorities. Even in these cases I will preserve your privacy to the best of my ability. Please see your notice of privacy rights for more information. Please note that email communication is not secure or private. Any third-party requests to release your information will need to be reviewed and approved by you. You have the right to request and understand information shared, with whom it is shared, and for what reason it is shared. If you are using health insurance to pay for therapy, your insurance company may ask for information about your symptoms, your diagnosis, and my treatment methods. I will let you know if this should occur and what information the company has requested. Please understand that I have no control over how these records are handled by the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits.

Involvement of Other Professionals: My role in this relationship is therapeutic and psychological in nature. Any and all concerns about medical issues will need to be directed to a medical professional and I can assist you with options for contacting a medical provider if necessary. I am not able to prescribe medication but am able, with your permission, to collaborate with other professionals to assist in your medication management if medication is needed. Any contact with other professionals will require your written consent and release.

Access to Records: Your mental health records are maintained in paper form in a securely locked location. I will inform you if I transition your records to an electronic format, in which case they will be kept on a secure, password protected hard drive. Though your records will be kept confidential, you have the right to review your records at any time. You have the right to understand what is kept in your records and the right to fully understand plans for treatment.

HIPAA Notice of Policies and Practices: I am committed to preserving the privacy of your personal health information. Additionally, I am required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you may get access to this information. Please ask for a copy of the HIPAA Notice of Policies and Practices should you wish to have a copy for your records.

Client Rights: If at any time you feel that this psychotherapy relationship is not beneficial, you have the right to seek other services to best help with your needs. I will provide resources should you need them. You have the right to be fully informed before you begin a psychotherapy relationship. Any questions or concerns are welcome and encouraged.

Consent to Treatment: I, the client, understand that I have the right to not sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I also understand that any of the points in this document can be discussed and may be changed by mutual agreement at any time. I understand my rights to privacy and the exceptions to my rights to privacy, and that there are risks associated with treatment. I have read, or had read to me this document as well as the Notice of Privacy Practices document. I have discussed those points I did not understand and have had questions if any, fully answered. I agree to the points in this document and enter into therapy with this therapist as shown by my signature here.

Printed Name

Signature

Date