



# Roseway Counseling Services

150 South East 80<sup>th</sup> Ave  
Portland, Oregon 97215

503-320-0762  
www.rosewaycs.com

S Elizabeth Limbocker, LMFT



## POLICIES AND INFORMATION

### I. Types of Therapy

The type of therapy that I do is varied according to the particular needs of you, the client(s). Normally, at our initial consultation we evaluate together what type of therapy is appropriate, what issues to target, and how many sessions you may need and whether or not we might work well together. If we decide to work together, we will set an appointment schedule to follow for treatment. If we decide we are not a good fit, for whatever reason, I will help you find other referrals and help in the referral process.

Please check EACH type of therapy you feel may be appropriate:

- Marriage or Relationship Therapy
- Family Therapy
- Individual Therapy
- Teen Therapy
- Other \_\_\_\_\_

### II. Areas of Treatment

Please check the areas or symptoms for which you are seeking treatment:

- |  |   |
|--|---|
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Marital Issues     |
| <input type="checkbox"/> Low self-esteem         | <input type="checkbox"/> Parenting Problems |
| <input type="checkbox"/> Unhealthy Relationships | <input type="checkbox"/> Spiritual Issues   |
| <input type="checkbox"/> Stress-Related Symptoms | <input type="checkbox"/> Other _____        |

### III. The Structure of the Session

The initial meeting is considered a consultation to explore the issues at hand and the fit between therapist and client. It may last from 30-50 minutes. All scheduled appointments after the initial interview are considered regular sessions. Regular sessions will usually consist of 50-minute sessions once per week. Often times in relationship/family work, part of the session is spent meeting with each individual alone, then all parties together. A longer session time may be negotiated should the need warrant.

Phone calls with the therapist of a substantial length or including content other than that needed for scheduling, canceling or rescheduling appointments will be treated as therapeutic and billed a pro-rated fee based on your session fee.

### IV. Fee Schedule

The fee for therapy is \$100 per 50-minute hour, \$125 per 75 minutes or \$140 per 90 minutes. The fee amount does not include formal assessment devices. Assessments are charged separately, as needed. If there is a financial hardship, please communicate this to me and we can discuss a

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possible fee adjustment.

**\* Please note**

- All fees will be payable at the beginning of each session via check or cash- no exceptions unless agreed upon in advance with the therapist.
- **I must receive cancellation notification by 5:00 p.m. the previous day to your scheduled appointment.** If you do not cancel an appointment by this time and yet are unable to make it, **you may be billed 50% of the scheduled session fee.**
- **If you do not show for an appointment and you have not called to cancel prior to the session, you may be billed for the full payment of the session.**
- If your payment by check is returned due to non-sufficient funds, you will be charged for any NSF and bank penalty fees.

If you have questions about the fees and cancellation policy, please discuss them with me, otherwise, please sign the following agreement.

I understand the above fees and cancellation policy. I agree to pay the amount due, as stated above, at the time of services. I agree to pay the fees for missed appointments and/or for appointments where the therapist has not received sufficient cancellation notice, as stated above. I agree to pay the NSF and bank penalty fees, should any be applied.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **V. Spirituality and Religion**

I respect your religious and spiritual beliefs and differences. I feel very comfortable if you choose to include these in your therapy session. I also respect your right not to include this aspect of your life in your session. Please feel free to discuss this subject with me.

## **VI. Risk of Therapy and Informed Consent**

I have chosen to discuss the risks of therapy out of an ethical commitment to helping you make an informed choice to participate in therapy. The greatest risk of therapy is that it may not, by itself, resolve your problem or concern. Thus, I do my best to assess progress on a week-to-week basis. Another risk to therapy is that symptoms might get worse before they get better. This is sometimes the case as you may be exploring issues ignored in the past, or asked to try a new approach or skill. Chronic non-improvement is treated as a reason for immediate referral. Unusual risk inherent in any prescription will be described at the time to the best of my ability and alternatives will be offered. Please feel free to discuss openly with me any aspect of your therapy or to ask any questions. I look forward to being a part of your treatment process and I feel privileged that you have chosen me to be a part of your work.

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**When you have read to this point and have asked for clarification, if necessary, please read the following and sign below.**

I have read and understand the statements on the previous pages and the risks of therapy. My signature below indicates that I give my full and informed consent to receive services.

In the case that treatment is for the minor child for whom I am a parent or guardian, my signature is to certify that I give permission to the therapist named above for the treatment of my child(ren):\_\_\_\_\_.

Name of child(ren)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date

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