

Brian H. Farr, MA, LPC
1020 SW Taylor Street, Suite 820
Portland OR 97205 503-224-0114

CONSENT FOR COUNSELING SERVICES AND FINANCIAL POLICIES

I have read the Professional Disclosure Statement describing the counseling practice of Brian H. Farr, MA, LPC. I request and give consent to receive counseling services as described by the Disclosure Statement.

I acknowledge receipt of the HIPPA "Notice of Policies and Practices to Protect the Privacy of Your Health Information".

I have been informed about the limits of confidentiality in counseling sessions. In particular, I understand that Mr. Farr may be required to disclose my protected health information (PHI) if he judges that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm to myself or other individuals. This disclosure of PHI may include government mandated protective services for children, elderly, or disabled individuals. If I have any questions or concerns about confidentiality, I will discuss them with Mr. Farr before I reveal sensitive, personal information.

In the event that Mr. Farr becomes disabled and is unable to contact me, I authorize Mr. Farr's designated professional colleague to contact me by telephone or written letter for purposes of notification and future scheduling. I understand that Mr. Farr is only available for consultation during specified office hours; furthermore, I understand that if I experience an emergency when this office is closed, Mr. Farr's telephone voice message will direct me to contact the Multnomah County Crisis Line at 503-988-4888.

I understand that Mr. Farr **does not provide** legal advice, tax advice or advice concerning specific business decisions, financial transactions or investments.

I agree to pay Mr. Farr for counseling services as described in the Disclosure Statement. I understand **full payment is expected from me at each session**. (Returned checks will be charged a \$10 service fee.) I also understand that in certain circumstances, Mr. Farr will be able to provide me with Health Insurance Reimbursement Forms. I understand that any payments I may (or may not) receive from my insurance provider are strictly dependent upon the policies of my insurance provider; and furthermore, such payments (or absence of such payments) are completely separate from my agreement to pay for counseling services as described in the Disclosure Statement.

Finally, I agree to pay Mr. Farr in full for any scheduled appointment that I do not attend, unless I provide at least **24 hours advance notice for cancellation** of that appointment.

Printed Name _____

Signature _____

Date: _____

Witness: _____

Date: _____