



Northwest Creative Therapy LLC

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Northwest Creative Therapy, LLC

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Welcome to Northwest Creative Therapy. Please take a few minutes to read the following important policies. Feel free to ask any questions you may have before signing this form.

CONFIDENTIALITY:

Therapy sessions are confidential. I will not share a client's information without written consent. The exceptions to confidentiality are for the following circumstances: threat of serious harm to yourself or others; child or elderly abuse or neglect; a medical emergency; a court order; collection of delinquent accounts. Legal guardians will be notified if their minor children report suicidal intent.

APPOINTMENTS:

Each session is 60 minutes in length. If you are unable to keep your appointment, 24 hour notice is required. Except in the case of an emergency or illness, you will be charged \$60 for any sessions missed without a 24 hour advance notice. The telephone number at the top of this page is available 24 hours a day. I check my messages frequently throughout the day. **In the event of a mental health crisis, please call the Multnomah County Crisis Line at 503-988-4888.**

FEES:

Initial intake assessments are \$165.00. The fee for 60-minute individual and couple sessions is \$135.00 with payment required at the conclusion of each session. If insurance is being billed, a co-pay is required at the end of the session. Client (or responsible party signing below if client is a minor) is responsible for payment. Payment by cash, check or credit/debit cards is accepted. Please make checks out to Northwest Creative Therapy LLC. In the event that payment is not received at the end of a session, or any fees are owed for missed appointments, the balance owed must be paid before another session can be scheduled. Please note that I reserve the right to submit any accounts more than 60 days delinquent to a collection agency. I will make a reasonable effort to work with you to avoid such a circumstance. However, by signing below you understand that confidentiality will, by necessity, be broken in order to turn your account over for collection.

CONSENT TO TREATMENT:

Your signature below indicates that you have read and agree to the policies stated above. If, at any time, you have concerns or questions regarding your therapy or these policies, please feel free to discuss them with me. You have the right to refuse treatment at any time, and to request a referral to another therapist.

Client's Signature _____ Date _____

Client's Signature _____ Date _____

Responsible
Party's Signature _____ Date _____
(if client is a minor)