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**Informed Consent to Treatment Agreement  
And  
Professional Disclosure Statement**

**Philosophy and Approach:** Every person comes to counseling with a unique background and need. In some situations ways of dealing with things that were effective in the past may no longer work. Others may be seeking enhanced wellness or balance in their lives. Counseling begins with a safe and supportive relationship. Each person seeking counseling deserves to be seen and respected as an individual, and the counseling process must reflect this individuality. It is my job as a counselor to help my clients plan and use their personal strengths, resources, and supports to find new ways to live. Often the counseling process involves identifying one's values, as well as one's beliefs about oneself and the world. I use research-informed approaches to help my clients identify problem areas, create goals, and try new ways of doing things that work for them in their unique situation. My theoretical approach to counseling is integrative, but draws from Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (a type of CBT), and Existential Theory. As a professional counselor licensed by the Oregon Board of Licensed Professional Counselors and Therapists I abide by its Code of Ethics.

**Formal Education and Training:** I hold a Master's Degree (MA) in Counseling Psychology from Lewis & Clark College, Graduate School of Education and Counseling and hold professional membership in the American Counseling Association. I am also a Certified Drug and Alcohol Counselor I (CADCI), a Nationally Certified Counselor (NCC), and a professional counselor (LPC) licensed by the Oregon Board of Licensed Professional Counselors and Therapists. My training includes: working with individuals and families; lifespan development; treating people experiencing anxiety and depression; cultural diversity; treating people who have experienced trauma and abuse; treating individuals with personality disorders; interpersonal effectiveness and communication strategies; diagnosis and assessment; Somatic Psychology; Cognitive Behavioral Therapy; Dialectical Behavior Therapy; Motivational Interviewing; treating people with addictions; and other treatments, modalities and interventions.

**Confidentiality and Privacy:** My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document. I will discuss privacy and confidentiality rights with you. Please feel free to ask questions about confidentiality if they arise later in the counseling process as well.

**Records:** I am required to keep appropriate records of the counseling services that I provide. Your records are maintained in a secure location in my office. I keep records noting that you were here, your reasons for seeking counseling, the goals and progress of treatment, (when relevant and appropriate) diagnosis that corresponds to your symptoms, topics we discussed,

your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. If I am incapacitated, Karen Hixson LPC will be the custodian of my clinical records. She can be reached at 503.314.6027 or at karenhixson@mac.com.

**Fees:** I am currently seeing individual adults and adult couples. I have a sliding scale fee structure for client's paying out of pocket, ranging from \$45 to \$110 per 60-minute session. If you are seeing me through an insurance provider, there may be a co-pay or deductible determined by your insurance plan. Some out-of-network insurance benefits may be reimbursable to my clients; I am happy to provide you a receipt for services upon request. Please contact me 24 hours in advance if you need to reschedule or cancel an appointment. My policy is to charge the fee for a 60-minute session for a missed appointment not cancelled or rescheduled at least 24 hours in advance. Please pay all fees and co-pays at the time the service is provided.

**Emergencies and contact between sessions:** In case of a mental health emergency between scheduled appointments, please call the Multnomah County Crisis Line at (503) 988-4888 or go to a hospital. 911 is a phone number that can be dialed in the case of an emergency as well. You may call me and leave a message; I will do my best to get back to you within 48 hours. I do not communicate with clients via social networking. Email correspondence is not secure, therefore I can not ensure its confidentiality. As a business practice, I will return emails within 48 hours. Email is not a means of emergency communication. Please contact the Multnomah County Crisis Line in a mental health emergency at (503) 988-4888.

**Benefits & Risks of Therapy:** Your participation in counseling, unless ordered by a court of law, is voluntary. You will be engaged in determining treatment goals, discontinuing counseling, or requesting a referral to another counselor at any time.

While there are many benefits to counseling, counseling may bring to the surface uncomfortable or distressing feelings. This can be a productive or healing part of counseling, but it can also be temporarily disruptive to one's life.

**Referrals:** If for any reason I believe that I do not have the experience, training, or knowledge to help you toward your goals, I will refer you to another professional who is adequately trained to help you succeed.

**As a client of a professional counselor licensed by the Oregon Board of Professional Counselors and Therapist you have the following rights:**

To expect that a licensed professional counselor has met the minimal qualifications of training and experience required by state law;

To examine public records maintained by the Board and to have the Board confirm credentials of a licensed professional counselor;

To obtain a copy of the Code of Ethics;

To report complaints to the Board;

To be informed of the cost of professional services before receiving services;

To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to client or others; 3) Reporting information required in court proceedings or by Client's insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by client against licensee.

To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

If you have questions about other aspects of this disclosure statement or our work together, please let me know. I encourage you to ask questions at any time.

You may contact the Oregon Board of Licensed Professional Counselors and Therapists at the following:

Board of Counselors and Therapists  
3218 Pringle Rd. SE #250, Salem, OR 97302-6312  
(503) 378-5499

Client Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Gender/Pronoun \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Email \_\_\_\_\_ Fee/co-pay per session \_\_\_\_\_  
Insurance Provider \_\_\_\_\_ Insurance number \_\_\_\_\_  
Do you wish to receive emails for me? Y or N  
Phone number \_\_\_\_\_  
Do you wish for me to leave appointment information at this phone number? Y or N  
Occupation \_\_\_\_\_  
Place of employment \_\_\_\_\_  
Referred  
by \_\_\_\_\_

**Person to contact in an in-office medical emergency:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone number \_\_\_\_\_

**Medical Information (if applicable)**

Medical  
conditions \_\_\_\_\_  
Current  
medications \_\_\_\_\_  
Medical  
providers \_\_\_\_\_

**Previous Counseling/Therapy**

Most recent counselor/therapist \_\_\_\_\_  
Approximate start and end dates seen \_\_\_\_\_  
Focus of  
visits \_\_\_\_\_

**INFORMED CONSENT TO TREATMENT**

Your signature below indicates that you have read this Informed Consent to Treatment and Professional Disclosure Statement, and have received the Notice of Privacy Practices and agree to their terms.

\_\_\_\_\_ Signature of Client

\_\_\_\_\_ Printed Name Client

Date \_\_\_\_\_