

Possibility Coaching

Elizabeth Ka'onoihilani Towill, LCSW
liztowill.com



(541) 531-6523
300 SE Reed Market Road #245
Bend, OR 97701

OFFICE POLICIES

Welcome to my practice! Please take a few minutes to review my policies and procedures. This information introduces you to my practice and may help answer questions that you may have. If you have further questions after reading this or individual concerns not covered here, please feel free to ask me about them at any time. I am in the independent practice of psychotherapy.

Credentials: I am a licensed clinical social worker in Oregon. This means I have a Master's degree in Social Work from an accredited School of Social Work and have passed several state requirements to get my license. I have provided psychotherapy to adults, children, and couples for over eight years.

Risks and Benefits: Research has shown that the therapy methods I use have been shown to be effective with some but not all clients. I cannot guarantee positive results. External factors, such as events in the client's life or irregular attendance can interfere with the client's progress. In addition, at times, therapy can also lead clients to experience distress for a time as they are dealing with painful feelings. Please feel free at any time to raise with me your questions and/or concerns about the treatment I am providing.

Confidentiality: Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: 1) If I believe that you intend to do serious harm to yourself or another and you cannot or will not take the necessary steps to protect yourself or the other person; 2) If you inform me of harm done to a minor or elder adult I may be required to report this; 3) If a court subpoenas me to testify or subpoenas my records; and 4) If a non-custodial parent requests information regarding their child's treatment. Note: Since I do not bill your insurance company, there will be no need to release any information to them.

Fees: My fee is \$95 _____ per 55 minute session. I will expect payment at the time of sessions unless otherwise agreed to. Phone calls shorter than 10 minutes will not be charged for. You will be charged at my full rate for the services provided at your request or for your benefit, such as report writing, consultation with other professionals, school consultations, hospital visits, court appearances, or phone calls over 10 minutes with you or others.

Insurance: I do not work with insurance companies.

Appointments: Appointments are 55 minutes long. Please let me know if we need to reschedule your regular appointment time. Cancellations and missed appointments are billed unless we are able to reschedule your appointment during the same week. If you are late for an appointment, the session will end at the regular time and you will be charged for the full session.

Emergency Procedure: In case you need to talk to me urgently between sessions, please call my office number and I will get back to you as soon as possible. If you cannot wait for a call back, please call the Mental Health Crisis Line at (503) 988-4888, dial 911, or go to your nearest hospital emergency room.

Consent for Treatment: I have read this statement and understand it. By signing below I authorize Elizabeth Towill, LCSW to provide psychotherapy under the terms described above and understand that I have the right to terminate therapy at any time I desire. If a client is a minor, I give permission for psychological services to be provided to my child. I authorize the therapist above to use my personal health information for treatment and consultation as needed. I understand that I am also assuming ultimate financial responsibility for the cost of the treatment. I also agree that I have had the opportunity to discuss the potential benefits and risks of the therapy with my therapist. This consent may be revoked at any time in writing.

Name of Client

Signature of Client

Date

Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Date

Elizabeth K. Towill, LCSW

Name of Counselor

Signature of Counselor

Date