A Better Way Counseling Center
818 NW 17th Avenue
Portland, Oregon 97209
(503) 226-9061

GUIDELINES FOR PARTICIPATION IN GROUP THERAPY

I, _____, agree to participate in the psychotherapy group led by a counselor at A Better Way Counseling Center. I have met with a counselor at A Better Way Counseling Center and understand the following about my participation:

PARTICIPATION GUIDELINES: I understand that this group experience will be most beneficial if I take the responsibility to ask for what I need and/or want in the group, if I deal with others as honestly as possible, and if I give direct feedback to others. I have the right to request the same treatment from others.

I agree to:

let other members affect me and be willing to talk openly and honestly about these effects.

use a fair share of the time.

work actively on the problems that brought me to therapy and on those concerns that are identified during the course of therapy.

to not eat, smoke, or do anything else during the group that would distract me from what I am thinking, feeling, or imagining.

put thoughts and feelings into words.

ATTENDANCE: I agree to come to all the meetings on time and stay for the entire session. In the event of necessary absence or lateness, I will notify the group leader in advance.

CONFIDENTIALITY: I agree to keep personal information, which is revealed in the group, confidential and to encourage other group members to do the same. In speaking of this group outside of the therapy sessions, I agree to do so in a way that protects the identity of the other group members.

I understand that whatever is said to my group therapist in an individual session will be disclosed to other group members, unless my group therapist is also my individual therapist.

OUTSIDE CONTACT: I agree to keep the relationships in the group therapeutic, not social. Interactions that occur between or among members outside of the group are considered group business and need to be discussed at the next group meeting.

DISCONTINUATION: I agree to let the group participate in my decision to terminate. I agree to a minimum of 12 weeks total. If after 12 weeks I remain in the group, I agree to give four weeks notice of my intent to discontinue the group, and to be present at each of those four meetings.

FEES: The fee for the group is $55 per session payable either at the time of each session or on the last day of each month. Cancellation or failure to attend does not excuse the obligation for full payment each month. Any accounts that have not been paid in full by the end of the month may be charged 1% interest monthly.

Fee increases are sometimes necessary, and if so, I understand I will be notified in advance by the billing office. If I have billing questions I will direct those to my group counselor. I understand that I will also need to sign a financial agreement which explains in more detail my fees and responsibilities.

INSURANCE: Insurance forms are made out on the assumption that the client is currently insured and that he/she remains so during the span of therapy. If there are any questions about eligibility to receive insurance benefits for mental health treatment, please call the insurance company directly or speak to your group counselor.

Insurance companies will request a diagnosis and sometimes request information regarding therapy. This information will be provided unless there is an objection by the client. Lengthy reports for insurance companies and/or other medical personnel may incur a charge – these may or may not be reimbursed by the insurance company.

Missed appointments are not reimbursable by the insurance companies – appointments that are missed will be charged at the full fee and so noted on the billing statement.

Insurance is a contract between the client and his/her insurance company. I understand that A Better Way Counseling Center is not a party to this contract. I understand that A Better Way Counseling Center will not become involved in disputes between the client and the insurance company other than to supply factual information as necessary. I further understand that I am responsible for the timely payment of the account, regardless of the actions by the Insurance company.

CONFIDENTIALITY: THERAPIST OBLIGATIONS: The therapist will also keep group information confidential except in such cases as law or ethics require (such as Worker's compensation), or when the client permits such disclosure. Confidentiality will be broken by the therapist in the following situations: 1) the client is judged by the therapist to pose an immediate danger to self or others 2) such information is necessary to meet a medical emergency involving the client 3) the therapist has reason to believe that there is child or elder abuse. There may be partial disclosure for the purpose of supervision, clerical services, or nonpayment.

If it is important that information be received from or given to another source, I understand that I may be asked to sign a Release of Information form. Please read the Client Information form for more information about confidentiality.

EMERGENCIES: I will call my group counselor or my individual therapist if I have an emergency. I understand that I can also call the Multnomah County Mental Health Crisis Line at 503.988.4888.

I understand that I am responsible for the cost of evaluation, group screening, and/or treatment provided and in the manner described.

I further agree to authorize the staff of A Better Way Counseling Center in obtaining payment from my insurance company if I am not paying the full fee in lieu of payment by my insurance company. For such purposes, I hereby permit A Better Way Counseling Center to use the term "signature on file" in place of my original signature below.

I also understand that I am responsible for payment, regardless of the action of the insurance company.

I have read the above information and agree to the above conditions.

Client name _____

Signature _____ Date_____

Witness _____ Date _____