HOOD RIVER COUNSELING
CONSENT TO TREATMENT

Brian Wolff, LCSW, CADC-III
Hood River Counseling PC
704 Columbia St
Hood River, OR 97031

(541) 490-7399
(503) 914-6678 fax
bwolff@hoodrivercounseling.org
www.hoodrivercounseling.org

Licensed Clinical Social Worker
Certified Alcohol and Drug Counselor III
Masters in Social Work; Dual Disorder treatment: Eastern Washington University
Functional Family Therapist
Gottman Trained Therapist

My counseling work is based in the Social Work Systems Theory, which views issues within the surrounding context. I primarily work from a Solution Focused Therapy perspective, yet I incorporate: Motivational Interviewing, Functional Family Therapy, Crisis Intervention and Prevention, Dialectical Behavioral Therapy, Narrative Therapy, Gottman Couples Therapy and Cognitive Behavioral Therapy. I believe in strengths based, client center treatment that focuses on treating the individual as a whole person.

I abide by all rules and standards for training, experience and ethics required by the Oregon Board of Social Workers and I am a member of the National Association of Social Workers.

You have the right to privacy as defined by rule and law, including the exception to confidentiality of information obtained in the course of services that include the following: reported suspected child abuse, reporting imminent danger to client or others, reporting to relevant agencies, licensee consultation or supervision, defense of claims brought by client against licensee.

You have the right to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category, while receiving service.

Evaluation and intake: $200 per 50 minute session
Individual Therapy: $120 per 50 minute session
Family or Couples Therapy: $135 per 50 minute session
$50 Fee charged for all missed sessions without 24 hour notice.
Please note that insurance companies do not pay for missed appointments.
Insurance and Medicare accepted. Bills due over 90 days may be sent for collections.

In have read the above policies and agree to the terms. I have received notice of HIPPA policies. I have the right to refuse treatment at any point, and understand the limitations of confidentiality. I hereby give my consent to treatment.

Client Name (print):________________________________Date of Birth:___________________

Signature:____Date:____________________

Legal Guardian Signature:__________________________________Date:____________________