AUTUMN BENTON, LICENSED MARRIAGE AND FAMILY THERAPIST |CERTIFIED RUN WALK TALK ® CLINICIAN
Corvallis, OR. 97330 MOBILE: 541-554-3340| Sweatandfreshairrx@gmail.com

**PATIENT INFORMATION**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address (Number and Street, City, Zip Code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Gender \_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date \_\_\_\_\_\_\_\_\_\_\_

**PRACTICE POLICIES & INFORMED CONSENT TO TREATMENT**

**AUTUMN BENTON, LMFT, Run Walk Talk®**

Our initial visit is a consultation and does not indicate intent to treat.

PSYCHOTHERAPY SERVICES: *Psychotherapy has both risks and benefits.* Risks of psychotherapy include experiencing uncomfortable levels of difficult emotions, including sadness, guilt, anxiety, anger, loneliness, and helplessness. Treatment sometimes requires recalling painful memories and examining how they impact current functioning and mental health, which can be distressing. Benefits of therapy can include resolution of specific problems, reconciliation of relationships, improved interpersonal dynamics, and an overall improved ability to tolerate dicult feelings without using negative coping mechanisms. There is an expectation, but not a guarantee, that therapy will be beneficial and transformative to you should we choose to pursue working together. In order for treatment to be effective, you agree to provide the most accurate information about your current and past concerns and mental health treatment. You also agree to ask questions when you do not understand what is expected of you or you are concerned about the effects of treatment.

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CONFIDENTIALITY: *What we discuss in session is confidential* and will never be revealed to individuals or entities outside of this practice without your permission, except where disclosure is required by law, including but not limited to: 1) abuse or neglect of a child, dependent adult or elder; 2) danger of harm to yourself or others; 3) grave disability; 4) pursuant to legal proceedings. Your records (including assessment/evaluation and details about session content) will be protected in a locked box; I do not maintain electronic session notes in order to protect my patients from data breaches. To protect your privacy, if we encounter each other outside the scheduled meeting, I will not approach or greet you*.* If appropriate for your treatment, I may ask you to sign a release allowing me to communicate with your other providers or family members; however you may refuse or cancel this allowance in writing at any time. In certain instances in which coordination of treatment with other treatment providers is ethically required and considered best practice, you understand that refusing to allow me to coordinate care may result in my terminating treatment and referring you to other therapists. In order to provide patients with the best care possible, I often utilize the services of consultants (usually other therapists or psychiatrists); I will protect your identity, only disclosing minimal information about your case required for me to best receive guidance in treating you, unless you sign a release of information for this purpose which would allow me to discuss your case more fully, including by potentially disclosing information which would identify you.

WALKING/RUNNING SESSIONS: If you elect to engage in walking/running sessions with me, you understand that this form of treatment is entirely voluntary, is conducted exclusively outdoors, and you accept the possibility of our discussions being overheard by third parties. You also accept the possibility of being seen with me by others whom you may know, and who may approach us during session or ask you about the nature of our relationship; if we are approached during one of these sessions by someone you know, I will follow your lead – in fact, we will discuss this prior to walking/running and I will document your request in your file. Patients who wish to engage in walking/running also agree to complete a Waiver of Liability.

ELECTRONIC COMMUNICATION AND MARKETING: Please be advised that I do not provide clinical services via text or e-mail as these are not secure forms of communication, though some patients choose to use text and email for the purposes of scheduling appointments. If you initiate contact with me electronically, you are consenting to my responding to or engaging in contact with you via the same method, though I may choose not to do so at my discretion. Please note that though I use social media for marketing and frequently attend community events at which I identify myself as a therapist, I do not engage with existing patients on social media and do not disclose the nature of my relationship to any patients I see at events, in order to maintain confidentiality. If you found my services via social media, you understand that I will not engage with you on these public forums moving forward if you become my patient.

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CONSENT TO TELEHEALTH SERVICES: Telehealth services include phone and online video sessions, which may be utilized for initial session, or in the event that you or I cannot meet in person due to illness, scheduling conflict, difficulty due to transportation, or for other reasons. Due to licensing restrictions, my policy is that I do not provide telehealth services if you have left the state of Oregon. Please be advised that your insurance company may not reimburse you for telehealth services; if this is a concern for you, please check directly with your insurance company prior to engaging in telehealth sessions. By signing this agreement, you agree that any telehealth services you engage in are voluntary and provided for your convenience, and that all the same fees apply for telehealth as for in-person sessions. You also understand that I will make reasonable eorts to provide a secure experience for you, using HIPAA-compliant technology whenever available, but that security of electronic and phone communication can never be guaranteed, and you accept any risks associated with engaging in telehealth services. Please be advised that telehealth services are not always appropriate for every patient and that I reserve the right to refuse telehealth if I feel it is not clinically appropriate or could be harmful to you. Please also be advised that telehealth treatment has potential risks and limitations, including but not limited to the reduced ability of the clinician to intervene appropriately with a patient who is acutely ill and in danger of harm to self or others. For telehealth sessions, payment will be processed via credit card.



PROFESSIONAL FEES, INSURANCE, AND FINANCIAL AGREEMENT: If you request a statement (invoice) from me to submit to your insurance for possible reimbursement, please be advised that it requires disclosure of diagnoses, dates of our sessions, fees paid, and other codes. Also, please be aware that using your insurance for reimbursement creates a permanent record of your mental health diagnoses which I do not control, and which can have financial, personal, and professional consequences for you that you may not anticipate. I am happy to explain this to you if you have any questions. If you would still like statements for insurance reimbursement, please check with your insurance company to ensure your benefits prior to the start of treatment; I provide statements at the start of each month, for the previous month’s sessions. The session fee is discussed and confirmed by phone prior to your first appointment and will be documented by me in your chart. Payment is due at the end of each session*.* I accept checks, cash, and credit cards (via a HIPAA-compliant payment app called Ivy Pay). Please be advised that missed sessions due to late cancellation (with less than 48 hours’ notice) or for other reasons are not reimbursed by insurance, will be labeled as such on any statements, and you will be responsible for paying these fees in full. I reserve the right to increase my fees periodically and will give you 30 days’ notice. I maintain a very limited number of appointment spots for patients who cannot afford my full fee. If you are paying a reduced fee, you understand and agree that this fee is temporary; we may also discuss money management as part of our work together in order to support your goals. If your financial situation changes and

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you need a reduced fee, you should discuss this with me; if I do not have reduced fee spots available or we cannot agree on a mutually acceptable, temporarily reduced fee, I will provide you with referrals.

In addition to weekly appointments, it is my practice to charge patients on a prorated, per-minute basis for other professional services required, such as telephone conversations (e.g., with the patient, the patient’s other providers, or family members of the patient), attendance at meetings or consultations which you have requested, or any other time required to provide other services which you may request of me, including travel time for concierge sessions or consultations with other providers. If you request house calls or sessions in a location other than my oce, you agree to pay for travel time to and from your home or chosen location; I will inform you of the full cost of such a session in advance. Fees are based on our 50-minute session fee and pro-rated per minute.

**I am not a forensic therapist and do not oer court-related services** (e.g., letters, reports, evaluations, or expert testimony). If your case requires my participation, you will be expected to pay for all time required (including but not limited to time in court, time waiting, preparation time, and travel time) and all costs associated with my participation (including but not limited to travel and lodging), even if another party compels me to testify. I reserve the right to charge a half-day fee of $2,000 (up to four hours of my time) or $4,000 for a full day, not inclusive of travel or other expenses.

Should you fail to continue payments for service, legal means, including the use of a collection agency or small claims court, may be used to collect unpaid dues, in which case such costs will be included in the claim. Returned checks will incur the penalty charged by my bank, which you will be responsible for paying. If your treatment is being paid for by a third party (such as a parent, partner, or family member), you understand and agree that the third party has access to information about your treatment including your fee, attendance (including missed sessions); you agree to provide me with a signed release of information so I can communicate with this third party to coordinate payment. In the case of repeated missed appointments or late cancellations, I may ask you to provide a credit card on file to maintain treatment.

ATTENDANCE: Due to my commitment to each patient, I try to begin and end each session on time to the best of my ability. If you are late for a session, we must still end on time. My vacation schedule will be available to you in advance as best as I am able to provide, and I will provide the names of other therapists who are providing coverage for me. *You are responsible for keeping your appointments and will be charged for missed sessions.* ***If you must cancel a session, you must do so at least 48 hours prior to the session time or you will be responsible for payment; you will also be charged for sessions you miss without calling.*** Please do not come if you are ill; we will conduct your session by phone. If you miss or cancel scheduled appointments on a regular basis or more than twice in a month, you

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will lose that reserved session time and you may be administratively discharged from my care. My priority is always the growth and well-being of my patients, so repeated cancellations, even with 48 hours notice, may also result in my terminating our treatment relationship and referring you to other providers so that you can continue moving forward with your treatment.

PROFESSIONAL RECORDS: I am required to keep appropriate records of the psychotherapy services that I provide. I may decline access to your records if I determine there is a substantial risk of significant adverse or detrimental consequences. Otherwise, you have the right to a copy of your file. 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. You have the right to make a written request that a copy of your file be made available to any other health care provider; I reserve the right to charge a reasonable fee for the time and costs required to fulfill such requests.

CONTACT BETWEEN SESSIONS: *You are welcome to leave me a voicemail and I will do my best to return all phone calls within 24 hours of a business day.* In the case of emergencies that require a more immediate response, such as suicide, the first thing you should do is call 911 or go to your nearest emergency room. Please refrain from relaying personal information via text or email.

ENDING TREATMENT: Ideally we will work together to determine when your treatment will end. If you decide to end treatment independently, it is customary to schedule a session to discuss this with me. If I am ending treatment with you due to failure to comply with the above policies, I will attempt to discuss this with you in session or by phone, and if that is not possible, I will mail a certified letter to your mailing address on file that will include referrals, at which point I will no longer be your provider.

By signing below, you arm: *My decision to undergo treatment is voluntary. I have thoroughly read and accept the above information and will comply with the above policies. If I fail to do so, I understand that I may be discharged from treatment with this provider.*

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**Waiver of Liability, Assumption of Risk, and Indemnity Agreement for Out-of-Office Activities with Autumn Benton, LMFT**

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In consideration for voluntarily participating in therapy with Autumn Benton LMFT, I, for myself, and on behalf of my next of kin, heirs, assigns, and personal representatives, hereby agree to the following.

I am eighteen (18) years of age or older. I hereby consent to participate in out-of-office activities in relation to therapy services, including but not limited to participating in therapy while running, walking, and/or engaging in other activities, which are generally outdoors and physical in nature, and including any and all preparation, movement, or travel to engage in such activities (collectively, all of these activities are referred to as “Out-of-Office Activities”) with Autumn.

**Release/Waiver of Liability:** I, for myself and on behalf of my next of kin, heirs, assigns, and personal representatives, hereby release, forever discharge, waive, promise not to sue, and agree to hold Autumn harmless from any and all liability, claims, or demands whatsoever, including for personal injury, sickness, death, property damage or loss, and expenses of any nature whatsoever, including for personal injury, sickness, death, property damage or loss, and expenses of any nature whatsoever which may be incurred by me or my family, heirs or assigns because of my participation in any Out-of-Office Activities. This release includes, but is not limited to, any claims relating to Autumn’s negligence in relation to planning, organizing, or conducting the Out-of-Office Activities. Nothing stated herein, however, constitutes a waiver of liability for any professional malpractice in the conduct of therapy by Autumn.

**Indemnification:** I, for myself and on behalf of my next of kin, heirs, assigns, and personal representatives, agree to indemnify, hold harmless, and defend Autumn against all claims, actions, suits, procedures, causes of action, damages, losses, judgments, awards, costs, expenses, attorney’s fees, and other litigation or arbitration costs, which may in any way arise from my participation in the Out-of-Office Activities. I, for myself and on behalf of my next of kin, heirs, assigns, and personal representatives, hereby assume all risk of personal injury, sickness, death, property damage or loss, and expense as a result of participation in the Out-of-Office Activities.

**Assumption of Risks:** I recognize that there are certain inherent risks associated with the Out-of-Office Activities. I know that participation in running and walking programs carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. I know that running and walking are potentially hazardous activities and certify that I am in good health and physically fit to enter into these activities. I acknowledge that I am aware of the many risks involved in physical activity in general and running and walking specifically, which risks include (but are not limited to): 1) minor injuries such as scrapes, bruises, sprains and strains; (2) more serious injuries such as joint, muscle and bone injuries, concussions and other head injuries, heat-related injuries such as heat stroke and heat exhaustion, dehydration and overhydration conditions such as hyponatremia, and

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catastrophic injuries and conditions such as heart attacks and other conditions or injuries which could be fatal. I have read the previous paragraph and I know, understand, and appreciate these and other risks that are inherent in participating in road, trail, track, and beach running and walking and any conditioning and any cross-training activities associated with running and walking. I hereby assert that my participation is voluntary and that I knowingly assume all such risks and full responsibility for these.

I, for myself and on behalf of my next of kin, heirs, assigns, and personal representatives, hereby agree to hold harmless and indemnify Autumn, and any of Autumn’s employees and agents, for any liability as a result of negligent, willful, or intentional acts of myself in relation to the Out-of-Office Activities.

I, for myself and on behalf of my next of kin, heirs, assigns, and personal representatives, also hereby grant my permission, if Autumn deems it necessary, to take me to a doctor, medical provider, or hospital and hereby authorize medical treatment for me, including but not limited to emergency surgery or medical treatment, and assume the responsibility of all medical bills, if any, arising from or related to the Out-of-Office Activities.

I understand that this document is written to be as broad and inclusive as legally permitted by the State of Oregon. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms. I have read this document, and I am signing it freely.

I HAVE READ THIS TWO-PAGE WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT, AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT BY SIGNING THIS RELEASE, I VOLUNTARILY SURRENDER SUBSTANTIAL RIGHTS, INCLUDING MY RIGHT TO SUE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Printed Name Signature Date