Disclosure and Consent for Treatment (Psychologist)

General Information

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it. Your signature indicates that you agree to the stipulations set forth in this document and that you have received a copy of my HIPAA/Privacy Policy, which is always available for review. You can revoke this agreement in writing at any time. Please see the attached Individual Clinician Addendum for specific information about your individual provider.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. Psychotherapy is a collaborative process in which we will work together to determine your goals and the best ways to go about accomplishing them. The outcome of your treatment depends largely on your honest communication and willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, sadness, hopelessness, etc. You may feel worse before you feel better. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself. To get the most out of our work together, you can take responsibility for your part of the therapy process (show up on time, communicating cancellations timely, thinking about our sessions beforehand, completing assignments, be ready and motivated to make changes in your life, value directness in feedback, take risks, try new things, and apply the new coping strategies to your life). In some cases, referral to a physician or nurse practitioner for a medical evaluation or for pharmacological treatment may be advised in order to supplement your therapy.

First Appointment/Intake

Before our first appointment, you will be asked to complete your paperwork online through the client portal. During our first few sessions, I will collect some more detailed information to

supplement the paperwork you filled out to evaluate your needs and offer you some first impressions of what our work will include. We will then create a treatment plan together. The first few sessions especially will be an opportunity for you to evaluate whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you. If I do not feel like a good match for you, I would be happy to provide referrals to other mental health professionals. If you have questions about the psychotherapy process and recommendations, I would be happy to discuss them when they arise. You have the right and responsibility to choose a therapist and treatment modality that best meets your needs. You also have the right to refuse evaluation and/or treatment.

My practice is not designed to provide ongoing crisis management or treatment of concerns such as psychosis, substance abuse, violence, personality disorders, self-harm behaviors, or suicidal thoughts and intent. A higher level of care is needed for these types of concerns. If these concerns occur during your work with me, I will assist you in identifying appropriate referrals.

Treatment Length and Course of Treatment

We will work together to determine the optimal amount of time for our work. We will decide on an initial amount of sessions and reevaluate as needed based on the goals we set, progress toward those goals, and how things have gone so far.

Contact Information

You should be aware that emailing information to me is not a secure or confidential avenue of communication; it is important that you limit email communications to coordination or cancelation of appointments. Your signing this document indicates that you know this and accept this limitation of confidentiality should you decide to email me. **Do NOT contact me by email in an emergency.** Please be aware that I do not maintain 24-hour access to email and email is checked intermittently during normal business hours. Further, I will likely not be able to read emails prior to session, so please do not include information you believe is crucial for treatment. Instead, please write notes (many clients do so on their phones) and bring that to session so that we can discuss it together. Please note that phone sessions are only utilized in rare circumstances (i.e., when online therapy is not available due to technical issues, etc.).

Emergencies

If you are experiencing a psychiatric emergency, contact 911, call the King County Crisis Clinic (206-461-3222), or go to your nearest emergency room. Mental health emergencies can be

assessed at emergency rooms, though we often don't think of them as places to go in a mental health crisis.

If I am scheduled to be out of town, we can determine ahead of time whether you will benefit from seeing another therapist for a few sessions while I am away.

Fees

You are responsible for payment for services at the beginning of each session. I reevaluate my fees every quarter. I will give you a full 60 days notice in writing if I decide to raise your fees in order to allow you ample time to reassess your financial situation, make other financial arrangements, or find another therapist if needed.

Payments

As a Licensed Psychologist, I am insurance eligible for all insurance carriers in Washington State. I am not on panel with any insurance company. My clients see me on an out-of-network basis or pay for sessions out of pocket. If you would like to use your out-of-network benefits, please contact your insurance company prior to our first meeting and ask what the out-of-network reimbursement would be for outpatient, in-office psychotherapy. The specific amount of this reimbursement depends on your plan. I will provide you with the statements your insurance requires.

If your insurance company refuses to reimburse you, it is your responsibility to pay for that as well. You must arrange for any preauthorizations necessary. You may pay by cash, check, or credit card. Please make checks out to Thrive for the People, PLLC. If you choose to pay by card, you can pay at each session or have the information stored in our electronic practice management system and billed automatically after each session.

As a courtesy to you, our practice can submit your out-of-network claims at the end of each month to your insurance through Reimbursify. Our submitting of your claims does not guarantee that you will have out-of-network benefits or that your insurance will accept and reimburse you for your sessions. You can download the Reimbursify app to track the claims process. If you have coverage, your insurance will apply your fees to your deductibles or send you a reimbursement check if you have met your deductible. It is your responsibility to make sure that any claims submitted are accurate and ultimately go through by checking the Reimbursify app. It is your responsibility to follow up with your insurance company if you have questions or

concerns about your claims, if the claims were denied, or if the insurance company requires additional information.

Missed Payments/Unpaid Bills

A $30 fee will be charged for checks returned from your bank, a credit card transaction that is canceled for nonsufficient funds, or in any other situation in which payment is denied or charged back. I will never let your unpaid bill reach over the cost of one session. If payment of your account is neglected, or if the outstanding balance is over the cost of one session, I reserve the right to suspend treatment until your balance is paid. Outstanding balances past due more than 90 days may be sent to collection unless a negotiated payment schedule is adhered to. This would require me to disclose otherwise confidential information. Accounts sent to collections will incur an additional charge of $300 and 2% interest per month to help compensate for time and costs. Under these circumstances, you will be responsible for all expenses and costs, including collection fees, attorney fees, and other associated costs.

Late Arrival/Late Cancellation/No Shows

If you are late, you will be charged the full fee and we will end our session on time, and we will not run over into the next person's session. If you are more than 20 minutes late to the session, we will reschedule the session for another time and you will be charged the full fee. Should I be late for a session, I will make up the missed time or adjust your bill accordingly. I ask for a full 48 business hours prior notice for cancellations or rescheduled appointments. **For appointments that are canceled or no-showed without a full 48 business hours prior notice will be charged the full fee.** Insurance companies cannot be billed for such charges. Exceptions to these charges are serious or contagious illness (your own), emergencies, and certain conditions that can't be predicted (e.g., hazardous weather conditions). In these situations, please call me with as much prior notice as possible. If I find myself unable to make your appointment due to any emergency in my personal or professional life, I will do my best to give you 24 hours notice.

I will not contact you to reschedule after a late cancellation or no show. If you want to reschedule after a cancellation or no show, please email or call me to reschedule.

Confidentiality

Your participation in therapy, the content of our sessions, and any information you provide to me during our sessions are protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- To coordinate care with a person or facility I reasonably believe is providing you with health care;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;
- If, without prior written agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

For additional information regarding your confidentiality rights, please carefully review the attached HIPAA and Washington State Notice of Rights and Privacy Practices. If you have any questions regarding your confidentiality, the limits of confidentiality, or the exceptions to confidentiality, please let me know. I will be happy to discuss this with you further.

Working with Minors

If you are the parent or guardian of a minor who is seeking treatment, please know that under Washington State law, any child age 13 or older can independently consent to mental health treatment without your permission. In addition, parents or guardians may not generally access the treatment record of a client aged 13 or older without that client's written permission. If you are 13 years of age or older, you have the legal right to seek mental health treatment without obtaining permission from a parent or guardian.

When I am in a therapeutic relationship with you or your child, I am not able to also provide a recommendation, evaluation, or opinion, in any legal forum relating to child custody, visitation, or parenting plans. When working with a minor child, I will need to be provided with a copy of any existing parenting plan, custody orders, or any other similar documents, including any

changes or revisions made during the course of treatment. It is generally necessary that both parents or legal guardians consent to treatment of their minor child.

Insurance Benefits

Insurance companies and other third-party payers may require that I provide them with information regarding the services I provide to you. This information may include the type of service provided, the dates and times of service, your diagnosis, treatment plan, a description of impairment, progress of therapy, and case notes and summaries. If you do not want me to provide your confidential information to your insurance company, let me know so that we can discuss alternatives.

Consultation

I may utilize supervision or consultation to better serve your needs. Information about you will be described only to the extent necessary and confidentiality will be maintained. My supervisors and consultants are legally bound to keep the information confidential.

Confidentiality for Couples Therapy

The same confidentiality described in the section above applies to couples therapy. However, confidentiality may not be enforceable to the extent of individual therapy, and therefore may not be protected by law in the same way confidentiality of individual therapy may be protected. When couples enter into therapy, it is considered to be one unit. I find this particularly important in creating a space where both partners can feel safe. Therefore, I adhere to a “no secrets” policy.

Email, Social Networking, and Accidental Meetings Outside of Session

I strongly recommend that email only be used for business purposes, such as to schedule or change an appointment as I cannot guarantee email security. If you would like to discuss therapeutic issues, please phone me or speak to me in person. I will not respond to emails about treatment issues. We are entering into a professional relationship and therefore I cannot accept invitations to connect personally outside of therapy. I will not be able to accept invitations to become a contact or friend on sites such as Facebook or LinkedIn. This will apply even after you are no longer a client to ensure that you can return to therapy in the future. If we accidentally see each other outside of the therapy office, I will not acknowledge you first in order to maintain your confidentiality. You are welcome to approach me and introduce me to others however you

see fit. I will follow your lead in the conversation and disclose only the information that you disclose or request.

Records

Your Clinical Record includes information about why you are here, the impact of problems on your life, diagnosis, treatment goals, progress toward those goals, relevant history, records that I receive from other providers, professional consultations, billing records, and any reports that I have sent to anyone including your insurance carrier. You may examine or receive a copy of this Clinical Record by providing a written request. When you signed onto your insurance, you may have already agreed to release your records upon their request. Please be sure you understand what you have authorized your insurance company to request and how it impacts your privacy.

Termination

Ending relationships can be difficult. Therefore, it is important to have a termination process. The appropriate length of the termination depends on the length and intensity of the treatment. We will terminate treatment after appropriate discussion of the reasons and purpose of terminating. This can be for a variety of reasons, including completion of your goals, a determination that I am not a good fit for you, or if I believe that therapy is not being used effectively. “Booster sessions” are part of this process and generally how I recommend terminating (i.e., meeting more and more infrequently as things continue to go well). If therapy is terminated, but you would like to continue regular treatment, I will provide you with a list of qualified psychotherapists to treat you. If you have not scheduled an appointment for four consecutive weeks, cancel late for two appointments, or no show for two appointments, unless other arrangements have been made in advance, for legal and ethical reasons, I will assume that you are no longer interested in therapy; I will close down your file and consider the therapeutic relationship terminated.

Ethical Concerns

I strive to adhere to the highest possible professional standards of competence and ethics. If you have concerns about the treatment you are receiving, please talk with me about those concerns in session or contact me by writing. If you feel that I have behaved unprofessionally or unethically, you may contact the Department of Health, Examining Board of Psychology, at P.O. Box 47868, Olympia, WA, 98504-7869 or at (360) 753-2147 to file a complaint. A copy of the Acts of Unprofessional Conduct can be found in RCW 18.130.180.

Client Attestation and Consent to Treatment

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPAA and Washington State Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, you are attesting to your consent to participation in therapy services provided by the clinician identified in the attached Individual Provider Addendum.

Client Name (Printed): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Printed): _____

If signing on behalf of a minor child under 13 years of age, do you have legal authority to consent to services on behalf of your child? _____yes _____no

Clinician Name (Printed): _____

Clinician Signature: _____ Date: _____

Thrive for the People, PLLC
5306 Ballard Ave NW #212
Seattle, WA 98107
(206) 403-1148
contact@thriveforthepeople.com