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OFFICE POLICY STATEMENT

It is a pleasure to welcome you as a new patient. In order to acquaint you with the office policies, I have written a brief description of procedures and related therapy information.

APPOINTMENTS: All sessions are arranged by appointment only. Sessions are scheduled for 50 minutes unless other arrangements are made. Please be prompt to best use the time reserved for you. **If you arrive more than 10 minutes late, I will have to bill for a shorter service, which reimburses at a lower rate. You will be financially responsible for the difference between the service you scheduled and the actual time you used.**

CANCELLATIONS: To facilitate scheduling, twenty-four hour notice is required for cancellations and reschedules. The number (425) 452-0905 is available to take your message anytime. **Please do not email cancellations. You will be charged the regular hourly rate for missed appointments without prior notification. This time had been reserved especially for you. Please be aware that insurance companies will not reimburse for missed psychotherapy sessions, making you responsible for the entire fee.**

TELEPHONE: (425) 452-0905 is a 24-hour voice mail service available for emergencies, consultations, cancellations, or rescheduling. Due to the nature of an outpatient practice, it may not be possible to respond to your call immediately. If a situation requires an immediate response, please call the crisis clinic at (206) 461-3222, call 911, or go to the nearest hospital emergency room.

PRIVACY PRACTICES: Every attempt will be made in the first session to explain my Privacy Policy, address any restrictions to protected health information (PHI), and obtain a signature confirming receipt of my Notice of Privacy Practices (NPP). In those situations where a signature is not possible, I will document my attempts to obtain the signature and the reasons for not doing so. A copy of my NPP will be available in my office and updated as policies change. Any client or potential client may have access to a written copy of my Privacy Policy. I will obtain a written consent from all clients to release any and all information except when required by law. **Please do not email confidential information, as emails are not HIPAA compliant.**

FEES AND PAYMENT: The initial session or diagnostic interview charge is \$130.00. Fees for the following appointments are based on a rate of \$105.00 for a 50-minute psychotherapy session. Fees will be charged for emergency calls and consultations with you, phone calls, reports, and consultations with attorneys and other professionals. These fees will be incurred in proportion to the hourly charge.

Fees for service are due at the time the service is provided. Accounts due over 60 days will accrue interest at the rate of one percent per month on unpaid balances. If no payment has been made on accounts over 90 days, a \$20.00 late charge will be added and the account will be sent out of the office for further collection. Checks returned by your bank for non-sufficient funds will result in a \$15.00 NSF check fee.

If you have a balance, you will receive a monthly statement reflecting account activity. Please review this statement for accuracy and notify me of discrepancies. Any collection, legal fees, or costs necessary to collect unpaid balances will be your responsibility.

THIRD-PARTY PAYERS (Insurance, Managed Care, Crime Victims Compensation): You have the following two options. 1) Paying full fee for the services at the time they are rendered and submitting your own insurance claim. 2) I will bill your primary insurance company, on a monthly basis, while you pay your co-pay or co-insurance, as specified by your medical plan.

Client Initials

Some plans require that you obtain a referral from your primary care physician or insurance case manager before the first session. If your plan requires pre-authorization for coverage, it is your responsibility to obtain it or to pay for sessions yourself until it is obtained. There is no guarantee that your insurance company will pay for your sessions and you are responsible for your bill whether or not your insurance pays. It is your responsibility to advise me of any changes in your insurance, managed care, or other benefit plan.

THIRD-PARTY PAYER ISSUES:

CONFIDENTIALITY: It is important to be informed of the effect of changes in the health care industry on you. If you choose to use a third-party payer who “manages” benefits, your treatment here will be subject to utilization review by a managed care or insurance company. This usually requires disclosure of confidential information such as symptoms, diagnosis, treatment plan, and relevant history. For the purpose of audits, third-party payers also have access to clients’ treatment records once identifying information has been removed.

MEDICAL NECESSITY: “Medical necessity” is the criterion most often used to determine authorization for treatment. To be considered medically necessary, treatment must be for a mental disorder, directed toward alleviating the signs and symptoms of that disorder, and expected to improve the level of functioning. While treatment intended for self-improvement or personal growth is valuable, it will not be covered by most managed health plans. If you disagree with an insurance company’s authorization decision, you have the right to appeal that decision.

You have the right to choose whether or not to utilize your third-party payer benefits.

1. I choose to not use my third-party payer benefits. _____
(Please initial)
2. I choose to use my third-party payer benefits. I authorize the release of any medical or other information necessary to process this claim. I hereby assign payment of insurance benefits directly to Kathleen L. Anderson, LICSW _____
(Please initial)

EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE: I hold a BA from the University of California Los Angeles and a master’s degree in social work from the University of Washington. My Masters studies provided a foundation in developmental psychology, social dynamics, research and a specialization in children, adolescents, and families. There was also a requirement for a six and nine month internship program. Following completion of a graduate degree in social work, the state of Washington offers certification to individuals who have graduated from an accredited school of social work and have met extensive supervisory requirements and passed a national written examination. In order to grow professionally, I regularly attend continuing education trainings, participate in supervision, read clinical books, and work on my personal growth.

I work with children, adolescents, adults, couples, and families. I use a variety of therapeutic approaches in my work: psychodynamic, cognitive-behavioral, family systems, solution focused, and play therapy.

ABOUT PSYCHOTHERAPY: Generally, the first four to six sessions are devoted to evaluation and information gathering. These initial sessions are critical in helping you to clarify your goals and to evaluate your ability to work in a confidential and meaningful therapeutic relationship. Therapy is a reciprocal relationship, which facilitates personal awareness and growth. Oftentimes, the process of therapy requires an understanding of childhood and family issues. This process can be painful and may, initially, cause you to feel more discomfort. It is through the exploration of this painful material that growth and change can ensue leading to an increased sense of identity, personal power, creativity and purpose.

It is important for therapist and client to feel comfortable working with one another. At any time, you may refuse treatment or request a referral to another therapist. However, if you should experience any discomfort with the therapeutic approach or question the professional ethics or practice of our work together, please discuss this issue with me first so we can clarify or resolve it. If you believe that our discussion has not resolved the issue you may contact the Department of Health, Counselor’s Division, in Olympia at (360) 664-9098. The Department of Health also provides a pamphlet entitled, “Counseling or Hypnotherapy Clients”, outlining various acts of unprofessional conduct and the complaint process available to clients. You may request a copy of this brochure from me at any time.

Client Initials

The specific goals of the client help to determine the direction and content of therapy. Sessions often will focus on the exploration of the client’s thoughts, feelings, actions and relationships, in an effort to bring about understanding and change. Treatment typically ranges from six to twenty-four months, but shorter or longer therapy may be indicated. Sessions are generally scheduled weekly, but may be scheduled more frequently if necessary. Treatment ends at a mutually agreed upon time and it is in your best interest to discuss this before stopping treatment. A specific last session is usually scheduled to talk about ending therapy and to review your progress. This issue is particularly important in child psychotherapy where a sudden termination of psychotherapy is sometimes experienced as abandonment.

CONSENT FOR TREATMENT: State regulations require that you read all sections of this statement and that you sign the following prior to beginning therapy. The purpose of the “Counselor Credentialing Act” is to: (1) provide protection for public health and safety; and (2) empower the citizens of Washington State by providing a complaint process for acts of unprofessional conduct. Please read the statement below carefully or ask to have it read to you. If there is any part of this statement or the prior written information that you do not understand, please ask to have it clarified to your satisfaction.

For the protection of the public health and safety, counselors practicing counseling for a fee must be registered or certified with the Department of Licensing. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

I, _____, have read and understood the above statements.

Client signature

Date

If minor, guardian’s signature

Date

Therapist signature

Date