KATHLEEN L. ANDERSON, LICSW
1800 112th Avenue NE, Suite 320E
Bellevue, WA 98004
(425) 829-2650
License Number: LW00005412

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 45 or 60 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, a **forty-eight hour notice** is required for cancellations and rescheduling. (425) 829-2650 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 because your appointment time has been reserved for you. Insurance companies will not reimburse for missed psychotherapy sessions, making you responsible for the entire fee.**

TELEPHONE: (425) 829-2650 is a 24-hour voice mail available for emergencies, 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.

COMMUNICATING VIA TEXT: I strongly encourage clients to use the Signal app when scheduling and sending sensitive information because communication over regular text is not encrypted and therefore less secure.

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 request a written copy of my Privacy Policy. I require 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 $170.00. Sessions, which meet from 38-52 minutes, are considered 45 minute sessions by the American Medical Association (AMA) and are billed at a rate of $140. Sessions, which meet 53 minutes or longer, are considered 60 minute sessions by the AMA and are billed at a rate of $160. Couples therapy will be billed $165 for a 60-minute session. Fees will be charged for emergency calls which last longer than ten minutes; and 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 past 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 to 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.

_____ **Client Initials**

THIRD-PARTY PAYERS: (Such as 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 while you pay your co-pay or co-insurance as specified by your medical plan.

Some plans require you to 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 notify me of any changes in your insurance, managed care or other benefit plan.

INSURANCE ISSUES:

CONFIDENTIALITY: It is important to be informed of any changes in the health care industry on you. If you use insurance which "manages" benefits, your treatment may be subject to utilization review by your insurance company. This usually requires disclosure of confidential information such as symptoms, diagnosis, treatment plan, and relevant history. For the purpose of audits, insurance also has 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 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 insurance 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 insurance benefits.

1. I choose **not** to use my insurance benefits. _____
   (Please initial)
2. I choose **to use** my insurance benefits. I authorize the release of any medical information necessary to process claims. I hereby assign payment of insurance benefits directly to Kathleen L. Anderson, LICSW. _____
   (Please initial)

EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE: I have 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 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 licensure 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, read clinical books, and work on my personal growth.

I work with adolescents, adults, couples, and families. I use a variety of therapeutic approaches in my work: psychodynamic, Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Internal Family Systems Therapy (IFS), Emotionally Focused Therapy (EFT), and solution focused.

ANNUAL SABBATICAL: I will be out of the office annually for a 6-week sabbatical. Prior to the sabbatical, we can discuss resources and coverage while I am out of the office.

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.

_____ **Client Initials**

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.

The specific goals of the client help to determine the direction and content of therapy. Sessions often 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.

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