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Client Consent for Treatment:
Psychotherapy Information and Agreement for Psychological Services

Following is an explanation of the rights and responsibilities held by you as a psychotherapy client, and by me as your therapist. Please discuss with me any questions you have regarding what is included here.

Educational Background and Approach to Treatment

I hold a Ph.D. in Clinical Psychology from Saint Louis University in St. Louis, Missouri and am a licensed psychologist in the state of Washington. "Licensure" means that I have passed a national written examination and an examination of competency administered by the Washington State Examining Board of Psychology, and am therefore competent to engage in the independent practice of psychology. While I am a Psychologist Associate with the practice of *Associates in Behavioral Health, PLLC (ABH)*, I am an independent practitioner and am solely responsible for the services I provide. I completed my predoctoral internship at the Seattle VA Medical Center and postdoctoral fellowship at the University of Washington. My training has provided proficiencies in general outpatient psychotherapy with individuals, couples, and groups. Throughout my training, I have also developed a specialization in providing psychological support for clients and families adjusting to changes in physical and cognitive functioning, trauma, and chronic conditions.

As a general practitioner, I see people with a wide range of concerns. My approach integrates emotional-focused, cognitive-behavioral, brief psychodynamic, and interpersonal methods to help clients develop insight and change maladaptive ways of thinking, feeling, and behaving. I emphasize this multi-faceted background, as clients may be referred to me based on my training and use of cognitive-behavioral therapy (CBT), alone – perhaps with the belief that traditional CBT is the only therapeutically effective mental health treatment, globally. Cognitive and behavioral therapies are, in actuality, continually expanding, *diverse,* and compatible with therapeutic interventions to the extent that they may appear like something quite different. Within my practice, I incorporate evidence-supported approaches that are primarily acceptance-based and sometimes differ from expectations of what CBT 'looks like'. My aim to help clients reduce their distress and develop more meaningful lives by encouraging them to react *differently* to the wish to control or avoid painful emotional experiences that are part of our human nature. In therapy we may discuss current problems, as well as family history, and memories of past events as they relate to present distress. I may be active/directive in sessions, which means that I may point out many behaviors or patterns that appear to hinder your emotional growth, may suggest alternative perspectives to how you interpret various situations, and may even provide experiential exercises to approach outside of the therapy session. There are many other times, however, when I will simply listen in order to gain a better understanding of your emotional life and interpersonal style. I work with the experience of emotions, such as how they express themselves (in our bodies, thoughts, images) and find that we will benefit from listening to even the very painful without surrendering our values and actions.

Generally, the first one to three sessions are used to learn more about your presenting problem(s). This assessment includes talking to you and, with your permission, may include talking to other relevant persons (e.g., family members or friends). After the assessment process, I may refer you to another therapist if, in my judgment, my expertise does not match your needs. In turn, you have every right to discuss our fit, and I am happy to provide referrals to competent providers at any point. Therapy will continue until goals are met, or until you decide that you wish to discontinue. Please feel free to discuss any questions you have with me throughout our work

together. I will utilize my experience, education and training in working with you and pledge to perform my services in a professional, competent manner.

Confidentiality

All issues discussed in the course of therapy are strictly confidential. Information concerning treatment or evaluation may be released only with the written consent of the client or the client's parent or guardian. However, please be aware of the following situations in which I may be required (e.g., ethically, legally) to release information otherwise regarded as confidential:

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect the intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform the proper authorities within 48 hours.
3. If I believe that you are in imminent danger of harming yourself, or are unable to take care of your basic needs, I may legally break confidentiality and call the police or the county mental health professionals.
4. As a result of new state regulations adopted in 2008 by the Washington State Department of Health, I am required to report myself or another healthcare provider in the event of a final determination of unprofessional conduct, a determination or risk to patient safety due to a mental or physical condition, or if I have actual knowledge of unprofessional conduct by another licensed provider. If you yourself are a healthcare provider, and I believe that your behavior constitutes a clear and present danger to your patients or clients, I am also required to report you. If you have any questions or concerns about this requirement, please talk with me about them.
5. If you disclose HIV infection, do not have a physician monitoring the condition, and have IV drug using or sexual partner(s), I may be obligated to report your identity and your partner's identity to the local public health authorities. I will first consult with the health care official without identifying you, as there may be an exception this ruling.
6. When ordered by a court of law to release information, or when required to comply with an investigation by the State Board of Health, Department of Psychology, I must release the requested information.
7. If you are using your health insurance to help pay for the cost of my services, your insurance company will require some degree of access to what is otherwise confidential information. At minimum, this will be a diagnosis and dates of services, but could extend to more detailed information, including session notes. Although highly personal information is never included in notes, they must be sensible and support continued therapy with a diagnosis and a treatment plan. By signing this "Psychotherapy Information and Agreement for Psychological Services", you are giving written authorization that I may release any information to your insurance company, or managed care organization, required by them to process any claims.

Further, the law allows the release of confidential information without your authorization in the following situations: a) to a person who I believe is providing health care to you, b) to any health care provider who I believe has previously provided you health care to the extent necessary for me to provide health care to you, unless you instruct me in writing not to make such disclosure, and finally c) to an immediate family member or any other individual with whom you have a close personal relationship if the disclosure is appropriate with good professional practice, unless you instruct me in writing not to make the disclosure. *In the event that I feel it is important to release any confidential information, I will make every reasonable effort to discuss this with you first.*

Appointments and Cancellations

You are responsible for coming to your sessions on time. If you are late, we will still end our session on time and not run past the 50 minutes, which may impede the next client's session. If you miss a session without canceling or cancel with less than 24 hours notice, you must pay for that session at our next regularly scheduled meeting. I ask that Monday clients, for example, let me know of any cancelations by Friday afternoon to allow for scheduling sessions with clients in need of or requesting a Monday session. I cannot submit a claim to your insurance company for a session that did not occur; this is considered insurance fraud as well as unethical as a psychologist. A charge to your account will be made without this 24 hours cancellation notice. The exceptions to this rule are illness, emergencies, and certain conditions that can't be predicted (e.g., icy roads). In these situations, please call me with as much notice as you can rather than waiting until the day of the appointment to cal. If I find myself unable to make your appointment due to any emergency in my personal or professional life (e.g., an urgent client-related matter), I will attempt to give you at least 24 hours notice. I respect the value of your time as well as my own.

Emergencies

I cannot be available for 24-hour therapy coverage. In the event of an emergency, you may call my office number (206-329-5255 ext. 311), leave a message, and/or follow the recorded instructions for emergencies, which include the option to have me paged. Please listen carefully to the instructions on my outgoing voicemail to ensure that your message is delivered. During non-business hours, I check messages infrequently. If am not able to return your call quickly enough, phone the Crisis Clinic at 206-461-3222, call 911, or go to the Emergency Room of the nearest hospital.

Fees and Insurance Coverage

You are responsible for paying for your session weekly unless we have made other arrangements in advance. My fee for intake (i.e., diagnostic assessment) sessions for individuals and couples is **$185** (no report). The fee for psychotherapy sessions for individuals and couples is **$140**. Therapy sessions are 50 minutes. If we decide to meet for a longer session, I will bill prorated on the hourly fee. Clients may choose to meet for roughly 90 min. for $185, for example. If paying for therapy presents a problem, please discuss this with me. In order to devote maximal time to your session, please have your check made out to **Dr. Erik Jackson** prior to our session.

The fee set for non-assessment sessions with you is $ 140 (unless noted otherwise:). Please initial your acknowledgment of the above fee here _____.

You are responsible for your account and are expected to pay for all services you receive. A $5 fee will be charged for checks returned from your bank to me for non-sufficient funds.

If you have insurance, you are responsible for providing me with the information I need to send in your bill. You should contact your insurance company if you have any questions about the exact percentage covered. You must arrange for any pre-authorizations necessary. At the time of each session, I would like you to pay for the percentage of my fee that your insurance does not cover. This includes deductibles and co-payments. Then, I will bill your insurance company directly for the outstanding balance. However, if your insurance company refuses to pay for the outstanding balance, it is your responsibility to pay for that as well. If you sign this form, you are giving written authorization that your insurance benefits are to be paid directly to me. Questions about billing and insurance may be directed either to me or to Craig Clow in the *Associates in Behavioral Health* billing office (ABHAS: 206-726-1790).

If, for any reason, you must carry a balance owing on your account, you will be expected to pay all of the balance within 30 days of receipt of a billing statement. If you are having financial

difficulties, we can discuss alternative payment schedules and/or treatment plans. If payment of your account is neglected, or if the outstanding balance is large, I reserve the right to suspend treatment until your balance is paid. Interest will be charged at 1.5% per month on outstanding balances that are past due more than 90 days. Outstanding balances past due more than 90 days shall be sent to collection unless a negotiated payment schedule is adhered to. Under these circumstances, you will be responsible for all expenses, including collection fees, reasonable attorney fees and other associated costs. If collection procedures or actions must be initiated on your account, only information necessary to assure collection will be released.

Additional Client Rights

As a client receiving psychological services, you have the right to the following: a) to have full and complete knowledge of my qualifications and training; b) to be informed regarding the terms under which services will be provided; c) to discuss your treatment with anyone you choose, including another therapist; d) to refuse treatment; e) to have access to your treatment records, make corrections to those records, and to have pertinent information shared with another therapist, or another party, provided you sign a release of information; and f) to end treatment at any time and request referral to another therapist.

Ethics and Professional Standards

As a licensed psychologist and member of the American Psychological Association, I am accountable for my work with you. If you have any concerns about the course of treatment, please discuss them with me. Remember that you have the right to discontinue your therapy or ask for a referral to another therapist at any time. Should you feel that I have been unethical or unprofessional, you may contact the Department of Licensing, Examining Board of Psychology, P.O. Box 47869, Olympia, WA 98504-7869. The phone number is 360-236-4910. You can also contact the Ethics Committee of the American Psychological Association, 750 – 1st Street N.E., Washington, DC 20002-4242.

1. **PLEASE SEE BELOW for Client Consent for Treatment form (sign and date the 2 copies)**

2. **See separate PRIVACY POLICIES document for review and consent.**

Client Consent for Treatment

My signature here certifies that I have read the disclosure statement form provided during my initial session for psychological services by Dr. Erik Jackson, and that all questions have been answered to my satisfaction.

I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I authorize Dr. Erik Jackson to provide assessment and/or psychotherapeutic services to me. I consent to the use of a diagnosis in billing and to the release of that information and other information necessary to complete the billing process. I understand that I am responsible for payment at the rate of $185 per intake evaluation session and $140 per session thereafter (unless another fee is agreed upon). I recognize that Dr. Jackson is an independent practitioner and is the only person with whom I am entering in an agreement with for psychological services; I can hold no other person responsible for the services provided.

Per rules provided by the Federal Trade Commission and designed to reduce healthcare-related identity theft, health care providers are required to request identification from our clients. The purpose of this policy is to flag possible cases of identity theft and fraudulent use of health insurance coverage. At your first visit I will ask for and make a copy of your identification (in the form of a driver's license, passport, or other government issued photo ID). My full identity theft prevention policy is available on request.

I recognize that no guarantees of treatment success can ever be made. I understand that Dr. Jackson will discuss general treatment goals/plan and diagnosis after several sessions. I understand I can end therapy at any time and can refuse any requests or suggestions made by Dr. Jackson. Recognizing this, I hereby give my consent for treatment and my signature indicates that I have agreed to the policies and procedures detailed in this document. This authorization constitutes informed consent without exception.

_____

Client Signature Date

_____

Erik R. Jackson, Ph.D. Date

Please remove this page and return as a permanent part of file:

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_____

Erik R. Jackson, Ph.D. Date