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Psychotherapy Information and Agreement for Psychological Services

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

Confidentiality

All issues discussed in the course of therapy are strictly confidential. By law, information concerning treatment or evaluation may be released only with the written consent of the person treated or such person'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 him/her 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. 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.
5. 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.
6. 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. If you sign 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: to a person who I believe is providing health care to you, 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 to an immediate family member or any other individual with whom you have a close personal relationship if the disclosure is made in accordance 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.

As a result of recent state regulations adopted 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 of 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 have any concerns about this requirement, please talk with me about them.

Rules provided by the Federal Trade Commission (FTC) require healthcare providers to request identification (ID) from our clients to flag possible cases of identity theft and fraudulent use of health insurance coverage. Thus, I will ask to see a copy of your ID (e.g., driver's license, passport, or other government issued photo ID). My full identity theft prevention policy is available upon request.

Appointments and Cancellations

You are responsible for coming to your sessions on time. If you are late, we will end our session on time and not run over into the next person's session. If you miss a session without canceling or cancel with less than 24 hours notice, you must pay for that session by our next regularly scheduled meeting. The fee for missed appointments is $85. I cannot submit to your insurance for payment any session that you did not attend, but I will charge you because you did not give me 24 hours cancellation notice. The exceptions to this rule are illness (your own), 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 call, though I understand that there may be instances when you become ill on the day of your appointment. If I find myself unable to make your appointment due to any emergency in my personal or professional life other than my own illness, 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 clinical coverage. In the event of an emergency, you may call my office number (206-329-5255), leave a message, and/or follow the recorded instructions for emergencies. 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 988, 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, e.g., we are submitting claims to your insurance company. My fee for intake (i.e., diagnostic assessment) appointments for individuals is $190. The fee for therapy sessions following the initial intake appointment (53+ minutes) for individuals is $170. If we decide to meet for a longer session, I will bill prorated on the hourly fee. If we decide to meet for a shorter session, I will bill prorated on the hourly fee. I have a limited number of "low fee" client slots in my practice. These slots are reserved for clients for whom the standard fee would present financial hardship. If paying for therapy presents a problem, please discuss this with me. I may from time to time change my fees and/or my policies and will post this document detailing updates on my individual page of our website *www.abhseattle.com*.

You are responsible for your account and are expected to pay for all services you receive. A 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 submit claims. You should contact your insurance company if you have any questions about the exact percentage covered. You must arrange for any pre-authorizations necessary. Your insurance will likely not cover deductibles and co-payments, so those will likely be your responsibility. That which your insurance company doesn't cover will be your responsibility. If you sign this "Psychotherapy Information and Agreement for Psychological Services" 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 my billing service *ABH Account Services* (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.

Educational Background and Approach to Treatment

I hold a Ph.D. in Clinical Psychology from the University of Oregon, and am a licensed psychologist in the state of Washington. "Licensure" means that I have passed a national written examination and an oral examination of competency administered by the Washington State Examining Board of Psychology. I also hold a clinical faculty appointment in the Department of Psychology at the University of Washington here in Seattle. I believe that participation in academic activities (e.g., teaching, research) informs my clinical work, as my clinical work has informed my teaching and research. While I am a Psychologist with *Associates in Behavioral Health, PLLC*, I am an independent practitioner and am solely responsible for the services I provide.

As a general practitioner, I see people with a wide range of concerns. My theoretical approach integrates cognitive, behavioral, and interpersonal methods to help clients develop insight and change maladaptive ways of thinking, feeling, and behaving. We will also address the influence(s) of current life stressors. 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). When necessary, the assessment may also involve the administration of psychological tests (e.g., symptom inventories). After the assessment process, I may refer you to another therapist if, in my judgment, my expertise does not match your needs. If I believe I can be of help to you, after the assessment process we will discuss a plan for treatment. 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.

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.

Client Consent

If you have questions about anything you've read here, please discuss them with me prior to signing this form. Your signature below indicates that you have read, understand, and agree to these policies and accept responsibility for payment of fees in accordance with these terms and conditions.

I understand my rights and responsibilities as a client, and my psychologist's responsibilities to me. I authorize Dr. David Markley 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 agree to pay the fee of $190 per intake session and $170 per session thereafter (unless another fee is agreed upon). I understand I can end therapy at any time and can refuse any requests or suggestions made by Dr. Markley. This authorization constitutes informed consent without exception.

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Client Signature Date

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David Markley, Ph.D. Date