

Elizabeth MacKenzie, Ph.D.
Licensed Psychologist
4204 SW Oregon Street
Seattle, WA 98116
Phone: (206) 932-2590

Please complete and
bring this form to
our appointment

Child Developmental History Record

A. Identifying Information

1. Child's name: _____ Birthdate: _____ Age: _____
Person(s) completing this form: _____ Today's date: _____

2. Parent #1 name: _____ Birthdate: _____ Home phone: _____
Address: _____
Currently employed: No Yes, as: _____ Work phone: _____
Name of employer: _____

3. Parent #2 name: _____ Birthdate: _____ Home phone: _____
Address: _____
Currently employed: No Yes, as: _____ Work phone: _____
Name of employer: _____

4. Parents are currently Married Divorced Remarried Domestic Partners Other
Child's legal guardian(s): _____

5. Stepparent's name: _____ Birthdate: _____ Home phone: _____
Address: _____
Currently employed: No Yes, as: _____ Work phone: _____
Name of employer: _____

B. Development

1. Pregnancy and birth
Prenatal medical illnesses and health care: _____

Was the child premature? _____ Weight and height at birth: _____
Any birth complications or problems? _____

2. The first few months of life
Sleep patterns or problems: _____

Personality/Temperament _____

3. Milestones: At what age did your child do each of these things?
Sat without support: _____ Crawled: _____
Walked without holding on: _____ Stayed dry all day: _____
Didn't soil his/her pants: _____ Stayed dry all night: _____
Dressed self completely: _____

4. Speech/language development: At what age did your child:
Said first words: _____ Three-word sentences _____

Any speech, hearing, or language difficulties? _____

Problems with frequent ear infections? Yes No

5. What are your child's strengths? _____

6. Friends: How many close friends does your child have? None 1 2 or 3 4 or more

Compared to other children of his/her age, how does your child get along with other children?
Poor 1 2 Average 3 4 Great 5

7. Household: Who else lives at home with your child?

Name	Age	Relationship (Mom, Dad, sister, brother, grandparent, step-parent, etc.)

Does your child split time between different households? ____ Yes ____ No

If yes, please describe: _____

8. Discipline. Who generally disciplines your child? _____

What methods are used? _____

Do parents (or other frequent caregivers) agree about discipline? Yes No

If no, please describe _____

C. Abuse/Trauma History

1. Has your child ever been sexually abused? Yes No
Describe: _____

By Whom? _____ CPS Report? Yes No
At what age? _____ Treatment? _____

2. Has your child ever been physically abused? Yes No
Describe: _____

By Whom? _____ CPS Report? Yes No
At what age? _____ Treatment? _____

3. Has your child experienced any recent or past traumatic events? Yes No
(e.g., death of parent or sibling, witnessing violence, car accident, etc.)

Describe: _____

At what age? _____ Treatment? _____

D. Health

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. Is your child taking any type of medication currently?

<u>Name of medication</u>	<u>Dosage</u>	<u>Reason</u>	<u>Dates</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Has your child ever taken any psychiatric medications in the past?

<u>Name of medication</u>	<u>Dosage</u>	<u>Reason</u>	<u>Dates</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Has your child ever had a vision screen or examination?

Date of screen: _____ Results: _____

4. Has your child ever had a hearing screen or assessment?

Date of screen: _____ Results: _____

5. Who is your child's primary care physician? _____

E. Family History

Parent 1

Name: _____

Educational level: _____

Occupation: _____

Parent 2

Name _____

Educational level: _____

Occupation: _____

Do any of your child's relatives have any of the following conditions? Please check all that apply, past or present.

	Biological Mother	Biological Father	Extended family	Child's siblings	Step-parent	Adoptive/ Foster Parent	Adoptive/ Foster Parent
Behavior Problems							
Mental Retardation							
Autism							
Learning Problems							
Attention Problems							
Hyperactivity							
Epilepsy							
Alcoholism							
Drug Abuse							
Depression							
Suicide							
Anxiety Disorder							
Bipolar Disorder							
Schizophrenia							
Psychosis							
Criminal History							

Are you your child's foster or adoptive parent? Yes No

If yes, please complete the following questions:

1. Your relationship to your child (circle one): adoptive parent/s foster parent/s
2. How old was your child when he/she started living with you? _____
3. Where did your child live prior to coming to your home? _____
4. Does your child have a relationship with any of his/her biological relatives? Yes _____ No _____

If yes, please explain: _____

5. Does your child know that one or more of his/her parents are not biological relatives?

_____ Yes _____ No If no, please explain _____

H. Concerns

1. What do you feel are your child's main problems or difficulties? _____

2. What do you think may have caused these concerns? _____

3. What have you been told by doctors, teachers, and/or others about your child's difficulties?

5. Has your child received any other mental health or special education evaluations or treatment?

6. Has any other member of your child's immediate family received mental health treatment or counseling?

I. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Please review and
bring this form to
our appointment.

Elizabeth MacKenzie, Ph.D
Licensed Psychologist
4204 SW Oregon Street
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Phone: 206.932.2590

Notice of Privacy Practices

Privacy is a very important concern for all those who come to this office. It is also complicated because of the many federal and state laws and professional ethics. Because the rules are so complicated some parts of this Notice are very detailed and you may have to read them several times to understand them. If you have any questions, I will be happy to help you understand my procedures and your rights.

Contents of this Notice

- A. Introduction**
- B. What is meant by your medical information?**
- C. Privacy and the laws about privacy**
- D. How your protected health information can be used and shared**
 - 1. Uses and disclosures *with your consent***
 - a. The basic uses and disclosures - For treatment, payment, and health care operations (TPO)**
 - b. Other uses and disclosures in health care**
 - 2. Uses and disclosures that *require* your Authorization**
 - 3. Uses and disclosures that *don't require* your Consent or Authorization**
 - 4. Uses and disclosures where you have *an opportunity to object***
 - 5. An *Accounting* of disclosures made**
- E. Your rights concerning your health information**
- F. If you have questions or problems**

A. Introduction

This Notice describes how I follow the laws regarding the handling of healthcare information. It tells how I use this information here in this office, how I share it with other professionals and organizations, and how you can see it. I want you to know all of this so that you can make the best decisions for yourself and your family. Because the laws of this state and the laws of federal government are very complicated and I don't want to make you read a lot that may not apply to you, I have removed a few small parts. If you have any questions or want to know more about anything in this Notice, please ask me for more details.

B. What is meant by your medical information

Each time you visit me or any other "healthcare provider", such as a pediatrician, you provide information about yourself and your family's physical and/or mental health. The information may deal with your past, present or future health or conditions, or the tests and treatment you or your child received from me or from others, or about payment for healthcare. The law calls this information, PHI, which stands for **Protected Health Information**. This information goes into you or your child's **medical or health care record** or file.

In this office this PHI is likely to include these kinds of information:

- Child developmental and school history.
- Family mental health, physical health, educational, marriage, and work history.
- Reasons you came for treatment. You and/or your child's problems, complaints, symptoms, or needs.
- Diagnoses, which are the medical terms for you or your child's difficulties or symptoms.
- A treatment plan, which includes a description of the services that I think will help you or your child.
- Progress notes. Each time you come in, I write down some things about how you and/or your child are doing based on what I observe and what you tell me.
- Records I receive from others who treated or evaluated you or your child.
- Psychological test scores, school records, and other reports.
- You or your child's medical history including past or present medications.
- Legal matters, such as documentation of custody evaluations.
- Billing and insurance information.

This is just a list to give you an idea; there is other information that may go into your healthcare record.

I use this information for many purposes. For example, I may use it:

- To plan your care and treatment.
- To decide how well treatment is working for you.
- When I talk with other healthcare professionals who are also treating you such as your family doctor or the professional who referred you to me.
- To show that you actually received the services from me which I billed to you or to your health insurance company.
- For public health officials trying to improve health care in this area of the country.
- To improve the way I do my job by measuring the results of my work.

Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You can read it and if you want a copy I can make one for you (but may charge you for the costs of copying and mailing, if you want it mailed to you). In some rare situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing you can ask me to amend (add

information to) your record although in some rare situations I don't have to agree to do that.

C. Privacy and the laws

I am also required to tell you about privacy because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA law requires me to keep your Personal Healthcare Information (or PHI) private and to give you this notice of my legal duties and my privacy practices, which is called the **Notice of Privacy Practices** (or **NPP**). I will obey the rules of this notice as long as it is in effect but if it is changed the rules of the new NPP will apply to all of the PHI I keep. If I change the NPP I will post the new Notice in my office where everyone can see it. You or anyone else can also get a copy from me at any time.

D. How your protected health information can be used and shared

When your information is read and used by me to make decisions about your care that is called, in the law, “**use**.” If the information is shared with or sent to others outside this office, that is called, in the law, “**disclosure**.” Except in some special circumstances, when I use your PHI here or disclose it to others I share only the **minimum necessary** PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used and to have a say in how it is shared.

I use and disclose PHI for several reasons. Mainly, I will use and disclose it for routine purposes (see below). For other uses I must tell you about them and have a written Authorization from you unless the law lets or requires me to make the disclosure without your authorization.

1. Uses and disclosures of PHI in healthcare with your consent

After you have read this Notice you will be asked to sign a separate **Consent form** to allow me to use and share your PHI. In almost all cases I intend to use your PHI here or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for my services, or some other business functions called health care **operations**. Together these routine purposes are called TPO and the Consent form allows me to use and disclose your PHI for TPO. Take a minute to re-read that last sentence until it is clear because it is very important. Next I will tell you more about TPO.

1a. For treatment, payment, or health care operations.

I need information about you and your condition to provide care to you. You have to agree to let me collect the information and to use it and share it to care for you properly. Therefore you must sign the Consent form before I begin to treat you because if you do not agree and consent I cannot treat you.

When you come to see me, I will collect information about you and all of it may go into your healthcare records. Generally, I may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called healthcare operations.

For treatment

I use your medical information to provide you with psychological treatments or services. These might include individual or family therapy, psychological or educational testing, treatment planning, or measuring the benefits of my services.

I may share or disclose your PHI to others who provide treatment to you. I am likely to share your information with your personal physician. I may refer you to other professionals or consultants for services I cannot provide. When I do this I need to tell them some things about you and your conditions. I will get back their findings and opinions and those will go into your records here. If you receive treatment in the future from other professionals I can also share your PHI with them.

For payment

I may use your information to bill you, your insurance, or others so I can be paid for the treatments I provide to you. I may contact your insurance company to check on exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

For health care operations

There are a few other ways I may use or disclose your PHI for what are called health care operations. For example, I may use your PHI to see where I can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If I do, your name and personal information will be removed from what I send.

1b. Other uses in healthcare

Appointment Reminders. I may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I usually can arrange that. Just tell me.

Treatment Alternatives. I may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other Benefits and Services. I may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Business Associates. There are some jobs I hire other businesses to do for me. In the law, they are called Business Associates. Examples include a copy service I use to make copies of health records and a billing service to figure out, print, and mail my bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy they have agreed in their contract with me to safeguard your information.

2. Uses and disclosures that require your Authorization

If I want to use your information for any purpose besides the TPO or those described above I need your permission on an **Authorization form**.

If you do authorize me to use or disclose your PHI, you can cancel that permission, in writing, at any time. After that time I will not use or disclose your information for the purposes that we agreed to. Of course, I cannot take back any information already disclosed with your permission or used in my office.

3. Uses and disclosures of PHI from mental health records that don't require a Consent or Authorization

The law lets me use and disclose some of your PHI without your consent or authorization in some cases. Here are examples of when I might have to share your information.

When required by law

There are some federal, state, or local laws which require me to disclose PHI.

- I have to report suspected child abuse or neglect.
- If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process I may have to release some of your PHI. I will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information requested.
- I have to disclose some information to the government agencies which check on me to see that I am obeying the privacy laws.

For law enforcement purposes

I may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

For public health activities

I might disclose some of your PHI to agencies which investigate diseases or injuries.

To prevent a serious threat to health or safety

If I come to believe that there is a serious threat to your health or safety or that of another person or the public I can disclose some of your PHI. I will only do this to persons who can prevent the danger.

4. Uses and disclosures where you have an opportunity to object

With your consent, I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want me to tell about your condition or treatment. You can tell me what you want and I will honor your wishes as long as it is not against the law. I will discuss limits to confidentiality for minors and children between the ages of 13-18 with all clients and parents prior to beginning treatment.

If it is an emergency and I cannot ask if you disagree, I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

5. An accounting of disclosures

When I disclose your PHI I may keep some records of where I sent it, when I sent it, and what I sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you.
4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing to me. You must tell me the reasons you want to make the changes.
5. You have the right to a copy of this notice. If I change this NPP I will post the new version in my office and you can always get a copy from me.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

Also, you may have other rights granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you need more information or have questions about the privacy practices described above please speak to me directly. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, you may speak to me directly. You have the right to file a complaint with me and with the Secretary of the Federal Department of Health and Human Services. I promise that I will not in any way limit your care here or take any actions against you if you complain.

If you have any questions regarding this Notice or my health information privacy policies, please contact me by phone at (206)932-2590.

The effective date of this notice is April 14, 2003

Elizabeth MacKenzie, PhD

Licensed Psychologist
4204 SW Oregon Street
Seattle, WA 98116
Phone: (206) 932-2590

Consent to use and disclose your health information:

This form is an agreement between parents, legal guardians, the adolescent client, and me, Elizabeth P. MacKenzie. The word “you” below refers to the adolescent client. The word, “parent” refers to both parents and legal guardians.

When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI). I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you and your parent/s are agreeing to let me use your information here and send it to others. The "Notice of Privacy Practices" explains in more detail client rights and how I can use and share client information. Please read the Notice before you sign this Consent form.

If you and your parent/s do not sign this consent form agreeing to what is in my Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and my Notice of Privacy Practices. If I do change it, I will post the changes and you can get a copy directly from me.

If you or your parent/s are concerned about some of your information, you have the right to ask me not to use or share some of your information. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you and your parent/s have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

(Turn over for signature page)

Consent to use and disclose health information (Continued)

Signature of client (age 13 or older)	Date
---------------------------------------	------

Printed name of client

Signature of parent or legal guardian	Date
---------------------------------------	------

Printed name of parent or legal guardian

Signature of parent or legal guardian	Date
---------------------------------------	------

Printed name of parent or legal guardian

Description of legal guardian's authority

Date of NPP _____ Copy given to the client/parent/legal guardian

Elizabeth MacKenzie, Ph.D.
Licensed Psychologist

Please review
and bring this
form to our
appointment.

DISCLOSURE AND POLICY STATEMENT

Welcome to my practice! This document contains important information about my professional services and business policies. Please read it carefully. Bring any questions or concerns you may have to our first meeting. Once we have discussed them and you feel you can make an informed decision about my services, I will ask you sign below to indicate you understand these policies.

Therapeutic Orientation and Psychological Services

I provide individual and family therapy for children, adolescents, and families, as well as psychological assessment. In conceptualizing a child or adolescent's difficulties and strengths, I consider the influences of heredity and temperament, developmental level, family relationships, cultural context, and other life experiences on thoughts, feelings, and behaviors. My primary treatment approaches are cognitive-behavioral and interpersonal, but I tailor my approach to the needs of the client.

When I first meet with families interested in psychotherapy or counseling services, I spend the first 1-2 sessions gathering information about your concerns and deciding if I have the expertise to be helpful to you, or if referral to a different professional would be more appropriate. During this time, you will be deciding whether you feel comfortable working with me. We can then discuss whether to continue together or pursue other referrals. Psychotherapy can have many positive effects, such as improved family and peer relationships, relief from symptoms, and better school performance. However, participating in psychotherapy is work. You may experience uncomfortable feelings such as sadness, anxiety, or anger during psychotherapy, and there are no guarantees. To achieve the best possible outcome for a child or adolescent, it is usually necessary for parents to take an active role so that positive changes may occur. This means that at different times therapy sessions may involve the parents alone, the child or adolescent alone, or the entire family together. I frequently give "homework" assignments so that skills may be practiced outside the office.

When I meet with families for psychological assessment (for example, learning disability assessment), I spend 2-3 sessions gathering background information and spending one-on-one time with your child to complete the tests. After the testing is complete, I have one meeting with parents to provide feedback, results, and additional recommendations.

Rights and Responsibilities of the Clients

It is your responsibility to choose the provider and type of treatment that best suits your needs. You have the right to ask questions about the evaluation results, and the right to raise questions about my therapeutic approach and the progress that is being made at any time. You have a right to discontinue therapy at any time and to receive referral to another therapist. If you are age 13 or older, you have the right to refuse evaluation or treatment. Please see my separate "Notice of Privacy Practices" for additional rights concerning the use of personal health care information.

Divorced or Separated Parents

When parents are separated or divorced, it is usually necessary for both parents to consent to evaluation or treatment for their child and to agree regarding payment for these services.

Confidentiality and Records

This office is compliant with the privacy rules of the *Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996*. Please see my separate "Notice of Privacy Practices" for detailed information regarding how I will handle health care information collected about you in my practice. By Washington state law, any person who is 13 years or older has the right to consent to outpatient mental health treatment without parental consent. In addition, persons age 13 or older have the right to decide to whom mental health information will be released, including to parents, unless the health care information falls under one of the exceptions to confidentiality (see "Notice of Privacy Practices"). However, the law also states that for clients between ages 13 and 18, the psychologist will act in the minor's best interest in deciding whether to disclose confidential information to the legal guardians without the minor's consent (WAC 246-924-363). By Washington State law (RCW 70.02.0505), I may disclose to parents or another of the minor's healthcare provider any behavior that may pose an imminent danger to the health or safety of the minor or another individual. For minors aged 13 to 18, information provided by parents in the context of the minor's evaluation or treatment is considered part of the minor's protected health information and is therefore documented in the minor's record.

Please understand that I am obligated to protect your confidences. In respect to keeping information shared with a psychologist confidential from parents, research shows that clients are more honest if confidences are protected. I will protect the information shared by adolescent clients unless a few specific situations arise. If any of these situations arise during treatment, I will remind you of the limits to confidentiality and make every effort to arrive at an agreement with you, my client, about the best way to inform your parents or other healthcare provider, of the situation so that we can keep you safe. These situations are listed in the sections that follow:

Non-accidental Self-Harm

None-accidental self-harm includes cutting, scratching, or burning yourself on purpose. It also includes thoughts, plans, or intentions to hurt your self.

Unsafe Eating or Exercise Behavior

Behaviors associated with eating disorders pose a medical risk and I will therefore need to act to protect your safety if you tell me that you are purging (making yourself vomit or using laxatives) or restricting your eating to the extent that your weight has fallen below or is at risk of falling below 90% of your ideal body weight. Excessive exercise may also fall under this category.

Drugs and Alcohol.

If you tell me that you are currently involved in the use of alcohol or drugs, your parents may need to be informed.

Other High Risk Behaviors.

It is impossible to list all behaviors that might pose an imminent danger to health or safety. Other examples of unsafe behaviors include unprotected sex, carrying a weapon, failing to take prescribed medication, and any other behavior that may pose an imminent danger to your health or safety.

To provide you with the best possible care, I sometimes consult with other mental health professionals regarding my cases. Information that could be used to identify the client or his/her family is not revealed during these consultations.

I share office space with a group of independent mental health professionals. Although we share certain expenses and administrative functions, I am completely independent in providing you with clinical services and I alone am responsible for those services. My professional records are stored separately and no member of the group can access them without your specific, written permission.

Contacting Me/Emergencies

You may leave a confidential voicemail message for me at (206) 932-2590, 24 hours a day. I check my messages regularly and will make every effort to return your call within 24 hours (with the exception of weekends and holidays). If you are difficult to reach, please inform me of some times when you will be available.

If you cannot wait for me to return an urgent call, call the Crisis Line at (206) 461 – 3222, go to the nearest emergency room, or dial 911. If I am gone for an extended period of time, I will arrange for a colleague to be available for urgent matters.

Appointments and Cancellations

Psychotherapy appointments are 50 minutes long, but we may agree to have shorter or longer sessions, depending on the clinical issue. Similarly, for psychotherapy, I typically meet with clients once per week, but we may decide to schedule sessions every other week or at longer intervals.

Your appointment time is set-aside exclusively for you, and I cannot fill that time slot without sufficient notice. To cancel an appointment, please provide at least **24 hours notice**, or you will be billed a \$50 late cancellation/missed appointment fee, unless we both agree that the appointment was unable to be kept due to circumstances beyond your control. If you will be arriving late to an appointment, please call my office as soon as possible so that I know you are coming and have not forgotten about the appointment. If you arrive late for an appointment, you will be billed the full fee for your session. Please note that insurance companies will not provide reimbursement for cancelled sessions.

Psychological assessment appointments are usually longer,, lasting 1 ½-2 hour sessions.

Fees and Billing

Psychotherapy

- **Initial evaluation and plan.** Before starting psychotherapy, I devote 1 session to completing an initial evaluation and plan. My fee for this session is **\$190**.
- **Psychotherapy sessions.** My fee for a 50-minute psychotherapy session is **\$140.00** (\$70 for ½ hour sessions). I also charge this amount on a pro-rated basis for other professional services, such as telephone calls lasting over 10 minutes.

Your co-payment is due at each visit unless we agree to other arrangements. If you are not using insurance or if you have elected to submit your own claims, full payment is due at the time of each session. Because I expect payment at the time of our meetings, I usually do not

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send bills. However, if we agree that I will bill you, I ask that the bill be paid within 5 days of when you get it.

Psychological Assessment

- **Initial Interview and Intake.** My fee for the first session, during which I gather background information such as educational, developmental, and relevant psychological history is **\$190**.
- **Testing & Report Writing.** My fee for psychological assessment, which includes time spent in interview, test administration, scoring, and report writing is **\$140/hour**.
- **Feedback.** My fee for interpretive feedback is **\$140/hour**. The purpose of the feedback session is to share assessment results and recommendations with you, answer any questions you might have, and to work with you to develop a plan to meet your child's needs.

One half of the estimated cost for the assessment is due at our first meeting. The balance is due at the feedback session. Many health insurance policies cover psychological assessment.

Other Professional Services

Sometimes families seek services which are not covered by insurance, for example, attending a school-based meeting, writing an individual behavior plan for your child's teacher, extended (over 10 minutes) phone or face-to-face consultation with the teacher, or providing documentation to support a request for accommodations (504 plan). I charge \$125/hour, which includes meeting and report-writing time. This fee also includes transportation to a school-based meeting, if the school is located outside of West Seattle.

Legal Matters

I prefer not to appear in any court proceedings. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$250.00 per hour for all time spent in connection with such appearances, including preparation and attendance at any legal proceeding. Payment for these services is due within 5 days of receiving a bill from me.

If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: 1) My statements would be seen as biased in your favor because we have a therapy relationship; and 2) The testimony might affect my relationship with you and your child; I must put this relationship first.

Other Payment, Billing Information

In the case of minor children, the parent who brings the child for treatment or assessment is responsible for payment. If you pay with a check that is later returned for insufficient funds, you will be charged an administrative fee of \$10 in addition to any other charges billed to me by my financial institution. If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collections agencies or small claims courts.

Insurance

To prioritize and set realistic treatment goals, it is important to evaluate your resources to pay for services. If you have health insurance, it will usually provide some coverage for psychotherapy. Many policies also provide some coverage for psychological testing. It is important that you find out the details of your coverage. Payment for the amount of fees not covered by insurance is collected at the time of service. I will fill out forms to help you receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of my fees. If your insurance company refuses to pay for the outstanding balance, you are responsible for the remaining payment.

It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they will reimburse mental health services. These plans are often limited to short-term treatments designed to help with particular problems that reduce a child's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis and information about how you are doing in order to justify treatment (See Notice of Privacy Practices for more information about this). Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Education, Training, and Licensure

I earned a B.S. with distinction in Psychology from the University of Washington. I received an M.A. and PhD in Clinical Psychology, with a specialization in child clinical psychology, from the University of North Carolina at Chapel Hill. I completed a child/pediatric specialty pre-doctoral clinical internship at the University of Florida Health Sciences Center, and a two-year postdoctoral fellowship in child clinical psychology at the Indiana University, Bloomington.

I am licensed as a psychologist in the state of Washington (PY#00002726). Psychology licensure ensures that psychologists have passed a national written exam and an oral examination given by the Washington State Examining Board of Psychology. I fully abide by the rules of the American Psychological Association and by those of my state license. Inquiries about my qualifications and any complaints about my professional services may be directed to: Department of Health, Examining Board of Psychology, 1300 Quince Street SE, P.O. Box 4769, Olympia, WA 98504, (360) 236-4700

CLIENTS AGE 13 AND OVER:

I have read and understand the above policies and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself.

Date

Client (13 years and older)

Date

Psychologist

PARENTS

I have read and understand the above policies and have had the opportunity to ask questions. I give permission for evaluation and treatment for my child, and state that I am the parent or legal guardian for this child,

Child's printed name

Date

Parent/Guardian Signature, Printed Name

Date

Parent/Guardian Signature, Printed Name

Date

Psychologist