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AGREEMENT FOR THE PROVISION OF CLINICAL PSYCHOLOGICAL SERVICES: OFFICE POLICIES AND PROCEDURES

INTRODUCTION: The following information is provided as required by state guidelines for disclosure of information to persons seeking psychological services. Thank you for seeking my services. Please read this policy statement carefully. It will explain to you what to expect (and not expect) from me in the performance of my psychological evaluation, treatment and consultation. If you understand and agree to the information contained in this statement, you will need to provide your signature at the end of the statement. Should you have any questions regarding the information contained here, please feel free to discuss your questions with me. In any event, I will discuss much of the following information with you before beginning the evaluation to ensure your understanding and answer any questions. Please be aware that despite an attempt to write this agreement in "plain English" that it is, nevertheless, a legally binding contract. Please read this agreement carefully before signing it.

ABOUT ME: I am a licensed clinical and forensic psychologist. Licensure of psychologists assures attention to the issue of competence and training, requires the psychologist to engage in ongoing continuing education to improve and update his skills and knowledge, and provides for a process to field complaints of unethical or unprofessional practice. I received my Ph.D. in clinical psychology from a university program accredited by the American Psychological Association. I am a member of the American Psychological Association and the Washington State Psychological Association and adhere to the Ethical Principles of Psychologists and the Standards for Providers of Psychological services adopted by the American Psychological Association. If at any time you believe I have acted unprofessionally or unethically, I invite you to bring the matter to my attention. Such complaints may also be addressed to the Examining Board of Psychology. Their address and phone number is included in the brochure "Considering Seeking Help from a Psychologist?" which you have been provided with this policy statement. Please feel free to ask questions you may have regarding my training, therapeutic approach and, as therapy continues, your progress. Of course, you have the right to seek psychological services elsewhere at any time.

THE THERAPY PROCESS: An effective evaluation and/or psychotherapy program requires openness, trust, a commitment to change and an attitude of collaboration. Since many of aspects of personal change are intangible, the success of any therapy program cannot be assured by your therapist. Much of your personal growth is your responsibility. Therapy will begin with an initial period of evaluation. During this time for those seen for more than one session I will ask you to complete a minimum of two or more psychological tests, (for example, the Minnesota Multiphasic Personality Inventory, a standard paper and pencil test measuring various aspects of your personality). This assessment helps the therapist to identify areas of concern and to become acquainted with you more rapidly and objectively. Be aware that you will be charged for the cost of scoring and interpretation of this diagnostic assessment. I will also conduct several clinical interviews with you for the purpose of history taking and identifying particular problem areas. At times I may ask you to complete questionnaires and "self-observation" records between sessions. These forms will ask you to observe certain types of thoughts, feelings, and behaviors and will serve as both a diagnostic tool and a baseline against which to measure your progress in therapy.

Depending upon the reason for your referral, I may also ask for copies of certain records. For example, I may wish to review any recent hospital records or to look at copies of any legal orders related to our work together. I may also wish to speak with your physician, particularly if you are presently taking any prescribed medication related to a

psychiatric problem. And, depending upon the nature of the presenting problem, I may wish to speak with members of your family.

If these secondary sources of information are needed, you will be asked to sign a Release of Information form which will provide your approval of such a release of records and discussions. Be aware that I will ask you to sign a general release form which allows me to discuss your situation with anyone who I think would be helpful to me in resolving your problem. If such records or discussions are necessary, you will be notified in advance for your approval.

Following the evaluation period we may review the results of your psychological tests and other assessment activities to arrive at a description of your present psychological problem(s) and strengths. We will also attempt to identify some reasonable goals of treatment and to establish some guidelines for an anticipated length of treatment.

The process of therapy itself will vary greatly depending upon the nature of your presenting problem, your skills and motivation, the number of people involved and a variety of other issues. My therapeutic orientation is eclectic, attempting to draw upon the best of a variety of theories and techniques. In general, however, you can anticipate that we will spend a good deal of time examining the relationships between the ways you think, feel and behave in particular situations. From time to time, I may ask you to complete "homework" assignments and to practice some of the skills we will be discussing in therapy. Group therapy will be utilized as a treatment option as needed.

PRACTICE HOURS AND APPOINTMENTS: Office appointments are available Monday through Friday between 8 AM and 5 PM. Although the length of sessions may vary somewhat, appointments are generally for 50-60 minutes. You can expect that the first diagnostic appointment will be somewhat longer and is typically a minimum of 100-120 minutes. Please keep in mind that your 50-60 minute appointment starts at the time you have been appointed, not when you arrive. Since your appointment time is held for your, I request 48 hours notice (two full working days) cancellation notice (excluding weekends and holidays) or the regular fee will be charged. As you can see, it is important that you regularly attend your psychotherapy sessions and do so in a timely manner. I will make every effort to honor all time commitments. On occasion, emergencies may cause delays and whenever possible you will be fully informed of such problems. Additional time will be scheduled for psychological testing. There is no charge for the testing time itself, only the scoring and interpretation (with the exception of intelligence and projective testing).

EMERGENCY CARE: I recognize that you can have an emergency situation arise and I will do my best to respond to your problems promptly. If you find it necessary to contact me after normal office hours, please call the office number ([206] 542-7516) and request that I am reached immediately by dialing extension 222. The voice mail will then contact me (or another psychologist if I am unavailable) and I will return your call as soon as possible. An additional fee may be charged for emergencies. Please keep available the phone number of your area's crisis clinic ([206] 461-3222) in Greater Seattle/King County and [425] 258-4357 in Greater Everett/Snohomish County) for use if I am not immediately available.

CONFIDENTIALITY: As a general rule, issues discussed in the course of treatment are confidential. As noted previously, when you sign a Release of Information Form you are authorizing me to give and receive information regarding your treatment to anyone I believe may help me in providing the best care possible for you. The laws of the State of Washington require that most issues discussed in the course of professional contact with a psychologist are confidential and privileged. However, the law requires the psychologist to disclose privileged information in certain situations. In very select instances, courts may subpoena treatment records. You should also be aware that I am ethically and legally required to report any admission of suggestion of abusive behavior to children or elderly persons. Also, if in my opinion, you represent a danger to either yourself or to others or are

unable to provide for your basic needs as a result of a mental disorder, I am required to notify the appropriate mental health authorities.

Under the Notice of information practices (70.07.120) of the Washington State Uniform Healthcare Act, we keep a record of the health care services we provide you. You may ask us to see and copy that record. Copy fees are determined by the Health Care Information Act. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

FEES AND PAYMENT: Fees for clinical diagnostic evaluation and treatment are $185 per 50-minute period. This fee will also be charged for my time in interviewing or consulting (including telephone contacts) with others related to your evaluation and treatment. Group therapy will be charged at a rate of $75 per session. Group therapy sessions typically last 75-minutes. Group therapy fees will be charged whether or not each group is attended in order to reserve your position in group. You will also be charged for tests administered and any necessary record review. The costs of tests vary depending upon the test. In the event that I am asked to serve in a forensic capacity or subpoenaed to appear as an expert witness in a legal proceeding, my fee is $275 per 60-minute hour (billed at the rate of $1,375 per half-day (five hours) and $2,750 per full day (ten hours) for deposition or expert testimony which does not includes any time necessary to prepare for such testimony (including attorney consultation, record review and travel time). A retainer will be required in advance of scheduling my time for Deposition or Expert Testimony. I will request a retainer before initiating forensic services unless other arrangements for payment have been made. This retainer to initiate forensic services is typically a minimum of $5,000. The retainer is non-refundable. Please be aware that my report will not be issued until your bill is paid in full. This retainer for preparation, Deposition and Expert Testimony is non-refundable. I will be happy to review these figures with you at any time.

Fees for searching and duplicating medical records are according to current WAC 246-08-400.

Payment is requested at the time that services are provided. A retainer will be requested before initiating evaluation/treatment or expert witness services unless other arrangements for payment have been made. Please be aware that reports, if they are requested, will not be issued until your final bill is paid in full.

If you have an appointment with me, I request at least 48-hours notification of cancellation (excluding weekends and holidays) so that your time can be reserved for someone else. If such notification is not given, you will be charged for the time reserved for your appointment. **You will be responsible for all charges incurred due to late cancellation or "no show" missed appointments even if my fees for your evaluation are being paid for by the State or another agency.** You agree that additional appointments will not be scheduled until all late cancellation and "no show" missed appointment fees have been paid.

Either cash or check may make payment, although checks are preferred. A finance charge of 1.5% per month (or a minimum service charge of $2), not to exceed the amount allowed by law, will be added to any balance not paid within 30 days after the service was received. Returned checks will be charged a fee of $50 each time they are returned by the bank.

COLLECTION: I agree that if an account is due for 90 days, it shall be sent for collection. I agree to pay all reasonable costs of collecting the bill, such as reasonable collection agency charges (which are typically 50% of the bill), reasonable attorney's fees, and court costs. I agree that the 50% collection agency charge shall be added to the bill and shall become my financial responsibility at the time the account is sent to the collection agency. I agree that I shall notify Dr. Olson's office at any time that I am uncertain of the status of the account or at any time that I fail to receive a statement of the account for a 30 day period.

TEST RESULTS AND REPORTS: You are entitled to receive feedback regarding the results of any evaluation of yourself. Verbal feedback will be provided during any appropriate therapy sessions. Written reports of results are not typical and Dr. Olson may decline to provide written reports. Estimated charges for reports of results shall be added to your bill and adjustments shall be made after the report is completed. Written results shall only be prepared and provided after all charges and estimated charges have been paid in full. Be forewarned that reports can take several hours to prepare (six to eight hours is typical per person) and can be quite expensive. Reports may not be covered by insurance. Due to the need to schedule time to write reports, reports often require several weeks to prepare.

INSURANCE AND INSURANCE FORMS: It may be that your insurance carrier covers some or all of my fees. If so, please pay me and attach my bill to the insurance company claim form. You may request an insurance billing form at the time of each visit. If, however, you do not receive such a form, it does not relinquish you from your responsibility to pay for the session at the time services are rendered. Typically, insurance billing is sent out at the end of each month. I recognize that questions regarding insurance matters are common. Please bring these questions to the attention of my office manager. We will be happy to assist you in any way possible. However, the agreement of the insurance company to pay for my services is a contract between you and the insurance company.

AGREEMENT: This contract constitutes our entire agreement on this matter. There are no other oral understandings or agreements between the parties not contained herein. Any modifications of the terms of this agreement must be in writing and signed by the parties hereto. You understand and agree that should Dr. Olson, at his sole discretion, choose to waive any requirement under the terms of this contract, such a waiver shall not be deemed a subsequent waiver of that requirement or any other requirement under the terms of this contract.

If you have any questions or concerns about the information contained on this form, please feel free to bring the matter to my attention. If you understand and agree to the above information, please sign and date below. You will be provided with a copy of this agreement for your records.

I am looking forward to working with you.

Name signed:_____ Name printed:_____

Executed this _____ day of _____, 201____, in the City of Seattle, King County, Washington.

Witness:_____ Date:_____