

**BRUCE ARTHUR OLSON, PH.D.**

CLINICAL AND FORENSIC PSYCHOLOGY

MEDICAL-DENTAL BUILDING OF RICHMOND HIGHLANDS

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**AGREEMENT FOR THE PROVISION OF FORENSIC 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 forensic psychological evaluation 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 and approach. Of course, you have the right to seek psychological services elsewhere at any time.

**DEFINITION:** I, the undersigned, understand and agree that a forensic psychological service is a psychological evaluation or consultation that is undertaken for potential legal purposes and that this agreement is a legally binding contract for the psychologist, Dr. Bruce A. Olson to provide for me such an evaluation and/or consultation. I understand that this contract constitutes the general policies and procedures aspects of the agreement between Dr. Olson and myself.

**THE EVALUATION PROCESS:** In evaluating you for the purposes of the present legal matter, I will depend upon a number of sources of information. I may administer to you one or more psychological tests, for example the Minnesota Multiphasic Personality Inventory (MMPI), a standard paper and pencil test measuring certain aspects of your personality. I will also perform one or more clinical interviews with you. Additionally, and depending upon the nature of the evaluation, I may also review pertinent hospital records, police reports, witness/victim statements and any other relevant information provided by yourself or your attorney. I will also be speaking with your attorney and such others as hospital staff members, police officers, health professionals familiar with you, members of your family, and others familiar with the present legal proceeding. You will be asked to sign a Release of Information form, which will provide your approval of such discussions. Be aware that this is a general release form and allows

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me to discuss your situation with anyone who I think would be helpful to me in coming to my conclusions and recommendations. It may be that the Court Order requires contacts.

In most cases a written report will be prepared outlining my findings. The report will be made available to your attorney and possibly to others involved in the present legal matter. The written report will outline the purpose of the evaluation, my sources of information, the results of my assessment and my conclusions and recommendations. In addressing the specific legal questions at hand, the report will consider your present and historical functioning with respect to such issues as your behavior, your thought processes and your emotional condition.

Forensic evaluations are typically complicated and labor intensive. The entire evaluation process will take, **at a minimum**, ten to twelve hours (for one person) of my time including record review, consultation, interviews and testing, and report writing. Most evaluations require a far greater expenditure of time. Depending upon the complexity of the case and the number of people involved, it is very possible that considerably more time could be required.

It is critical that you understand that regardless of the source of fees or referral for this evaluation, I operate as an independent evaluator and consultant. I will arrive at my conclusions in as unbiased and professional a manner as possible. My role and status will be equivalent to a court-appointed expert, even if the court orders no such formal appointment. As a consequence you should not necessarily expect that my conclusions and recommendations would support the outcome you may desire. In fact, it is possible that my impressions, opinions, conclusions and recommendations may be contrary to the position you would support or desire.

**SERVICE:** I understand that sessions typically start on the hour, that while some sessions are approximately 50 to 60 minutes in length other sessions may extend for several hours and that additional time shall be scheduled for record review, interview and testing. I agree that I am contracting only for Dr. Olson's time and service as an independent evaluator and consultant. I agree that as part of this service, Dr. Olson may form and provide findings, impressions, opinions, conclusions, and recommendations regarding the issue at hand. In consideration for Dr. Olson's agreement to perform this service, I agree that his role and legal status shall be that of a court appointed expert, even if the court orders no such formal appointment. I agree that I am not a therapy client of Dr. Olson and that this consultation is not for the purpose of therapy. I agree that since forensic consultations are only for the purpose of evaluation, Dr. Olson shall decline to provide me therapy--even if I request it--and shall instead provide me names of appropriate therapists at my request. If I am involved in a legal action and I have been referred for therapy rather than evaluation during ongoing litigation, I will sign and agree to Dr. Olson's "Clinical" Office Policies in addition to these "Forensic" Office Policies. Dr. Olson may charge his forensic rate at his option for therapy in a forensic context. In these situations, Dr. Olson will not be a forensic evaluator but will serve as a therapist in a forensic context.

I agree that there is no expectancy that Dr. Olson necessarily shall provide testimony on my behalf or necessarily shall advocate for any particular outcome that I support or desire. To the contrary, I agree that his findings, impressions, opinions, conclusions and recommendations may be adverse and detrimental to me and to my legal position. I agree that Dr. Olson may provide statements and testimony that are adverse to the outcome that I support or desire and may advocate for a different outcome than the one I support or desire.

**FEES AND PAYMENT:** Fees for record review, diagnostic evaluation, and report writing are \$275 per 60-minute hour. This rate also applies to my time spent in interviewing or consulting (including telephone contacts) with others related to your case. Testing will be charged at my usual and customary rate, which varies depending upon the

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tests administered. My fee for expert testimony is based on the rate of \$275 per hour. This rate will also apply to any time necessary to prepare for my testimony, including attorney consultations and record review. Please note that depositions and expert testimony will only be reserved and billed at the rate of \$1,375 per half-day (five-hours) and \$2,750 per full day (ten-hours) which does not include 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. This retainer for a Deposition, Preparation and Expert Testimony is non-refundable.

I will be happy to review these figures with you at any time. If it has been determined that you are unable to provide for these costs yourself, but are legally entitled to the services of a mental health expert, my fees may be paid for by the state. If this is the case, I will inform you of this prior to the evaluation. (Sentence that was here was moved to above.)

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

If you have made an appointment with me, I request at least 48-hours notification of cancellation (two full working days 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.

If the court has not provided for my services to you, you are responsible for their cost. Forensic evaluations may be very expensive as they are labor intensive. Payment is required at the time of service. I will request a retainer before initiating forensic services unless other arrangements for payment have been made. This retainer to initiate services is typically a minimum of \$3,500 for an individual and will be higher in complex cases. It is not an estimate of the cost of the evaluation. The retainer is non-refundable. Please be aware that my report will not be issued until your bill is paid in full.

Either cash or check may make payment. 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.

The cost of a forensic evaluation and expert testimony may or may not be covered by your insurance company. In any event, you are expected to pay me at the time of my service. I will give you an insurance billing form to submit for possible reimbursement by your insurance carrier. Typically insurance companies do not cover forensic services. My office manager will be happy to discuss insurance matters with you and to be of any assistance possible. However, the agreement of the insurance company to pay for my services is a contract between you and the company.

**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.

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**DISCLOSURE:** I agree to fully reveal all information that may relate to the issues at hand. I agree that being open and candid is essential and that being defensive or attempting to overlook faults, to minimize problems, or to blame others may be evaluated negatively.

**CONFIDENTIALITY:** As noted, when you sign the Release of Information Form you are authorizing me to give and receive information regarding your case to and from those who I believe may help me arrive at a well-informed opinion. My written report will be sent to your attorney and, if required, to others involved in making decisions about your present legal matter. If I am subpoenaed to appear in court or other legal proceeding regarding your case, my testimony will include any information, which you have provided to me, as well as information from other sources that I have used in arriving at my opinions. Because of the limits of confidentiality and your involvement in the present legal proceedings, you may refuse to speak with me if you wish.

I agree to sign a "Release of Confidential Information" form indicating that I waive any right that I might have to claim a psychologist-patient privilege. I agree that Dr. Olson shall accumulate and exchange any and all information with any person that Dr. Olson believes may be relevant to this consultation. I agree this release also includes Dr. Olson's use of professional test scoring services and other professional consultation as deemed advisable by Dr. Olson.

I understand that 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 and I agree that I am waiving that privilege. I understand that the law requires Dr. Olson to disclose privileged information in situations of suspected child abuse, of potential harm to oneself or another, and in instances where the court shall order the disclosure of privileged information and shall subpoena records.

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.

**CONFIDENTIALITY OF CHILDREN:** I agree that in order to protect any child's welfare and to help any child to feel more free to speak openly, Dr. Olson may promise to any child that might be involved in or relevant to this matter that what the child states to Dr. Olson shall be kept confidential if, in the opinion and sole discretion of Dr. Olson, it might be detrimental to the child to do otherwise. I agree that I shall not in any way attempt to discover the contents of such discussions between a child and Dr. Olson and I waive any legal right, claim, or privilege that I may have to that information unless and until a court rules otherwise.

**RESULTS:** I understand that written reports are not always necessary but may be requested by an attorney or the court. I understand that I am entitled to be provided an interpretation of the results of the evaluation of myself but I agree that I am not entitled copies of the psychological tests themselves or copies of the uninterpreted results of those tests. I agree that the provision of interpreted results shall be, at Dr. Olson's sole discretion, by Dr. Olson in person to me, through an attorney, be verbal or written report, or by testimony. Estimated charges for the provision of these results shall include fees for the preparation of reports and the copying of records and these charges shall be added to my bill. I agree that any results, reports, and copies of my records shall only be prepared, written, and provided after the full evaluation is completed and after all charges and all estimated charges relevant to the matter have been paid in full. I agree that partial reports will not be provided and that copies of records shall not be prepared or provided until after charges related to the matter are paid in full.

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I understand that written reports often require weeks to prepare because report writing usually takes from six to eight hours per adult involved and is scheduled just as an appointment. I agree that this report preparation and writing time shall only be scheduled after all tests and written materials have been returned, the evaluation is completed, all requested information has been provided, and all related accounts are paid in full including all estimated charges for the report(s). I agree that it is my responsibility to comply with the preceding requirements so as to allow Dr. Olson adequate time to prepare and provide results and other legal considerations. I agree that I, my attorney, or the court may request that Dr. Olson cancel another person's reserved time in order to provide a rush report or other legal consultation. I agree that such cancellation is at the sole option of Dr. Olson. I agree that the additional costs for such cancellations are at my expense.

I understand that after the evaluation is completed, I may schedule a session with Dr. Olson for the sole purpose of receiving feedback regarding the results of the psychological evaluation of myself and my children and that Dr. Olson may provide me up to 60 minutes of interview time for this purpose at his usual and customary fee.

**GUIDANCE:** I understand that Dr. Olson does not give legal advice and that legal advice and strategy are the province and area of expertise of my attorney. I agree to consult with my attorney before I take any action that might have legal implications.

**EMERGENCIES:** I understand that the 24-hour appointment phone number may be used to leave messages about a crisis or emergency. However, I agree that Dr. Olson's office is not expected or intended to respond to clinical or legal emergencies and that it is unlikely that Dr. Olson will get the message and return a phone call until the next business day. I agree that the role of Dr. Olson in a forensic evaluation is incompatible with that of providing therapy. The provision of therapy (of which crisis intervention is a type) is not part of the service of the forensic evaluation for which I am contracting. I agree to keep available the phone number of my therapist, my area's crisis clinic (461-3222 in greater Seattle/King County and 258-4357 in Greater Everett/Snohomish County), and my attorney in the event of a clinical or legal emergency.

**AGREEMENT:** I agree that all agreements and contracts between Dr. Olson and myself are in writing and that there are no oral agreements between Dr. Olson and myself in this matter. Any modification of the terms of this agreement must be in writing and signed by Dr. Olson and myself. I agree that should Dr. Olson, at his sole discretion, choose to waive any requirement under the terms of this contract, that that waiver shall not be deemed a subsequent waiver of that requirement or any other requirement under the terms of this contract.

I have carefully read and I have understood this contract. I understand and agree that this is a legally binding contract. I acknowledge that I have been given a copy of this contract. I agree that the provisions of this contract are reasonable, fair, equitable, and candid. I understand and agree to this contract without undue influence, duress, or coercion from any source. I agree that I have had the opportunity to consult with an attorney about any aspect of this contract. I knowingly, willingly, and without exception give my full informed consent to, and agree to abide by, each and every one of the provisions contained herein. I so indicate my statement of understanding, consent, agreement, and willingness by my signature below.

Again, if you have any questions about the information on this form, please bring the question 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.

Name Signed: \_\_\_\_\_

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Name Printed: \_\_\_\_\_

Executed this \_\_\_ day of \_\_\_\_\_, 201\_\_\_ in the City of Seattle, King County, Washington.

Witness: \_\_\_\_\_ Date: \_\_\_\_\_