**PRACTICE DISCLOSURE STATEMENT AND PERMISSION TO PROVIDE CARE**

**PURPOSE:** This document provides you with information about myself and my practice, to notify you of your rights and give me permission to provide care. This may help you decide if I am the right therapist for you. More information can be found on my web site: Kirklandpyschcare.com

**QUALIFICATIONS:** I have a Master’s Degree in Clinical Social and 30 plus years’ experience in the field of mental health. I seek continuing training to keep my skills current within the scope of my practice. My License number with the Washington State Department of Health is: LW00005341. Although I address a number of mental health issues in my practice, I have specific interest and training in couples and relationship therapy, the treatment of anxiety and mood disorders, stress management, trauma-related conditions, and the treatment of children and adolescents.

**APPROACH TO TREATMENT:** Currently, I use a variety of approaches including among others, Psychodynamic, Interpersonal Psychotherapy, Cognitive Behavioral Therapy, Cognitive Affective Therapy, Communication skill coaching, and Mindfulness Techniques. The scope of our work together will include a thorough assessment, treatment planning once known, and agreed-upon goal setting. We can discuss the progress of your work at any time, and I will make treatment recommendations accordingly. Please feel free to ask any questions. More information can be found at KirklandPsychCare.com.

**THE PROCESS OF THERAPY:** Participating in therapy can result in a number of benefits to you, including a better understanding of yourself and others, clarifying goals and values, improved interpersonal relationships, and resolution of the specific concerns

that led you to seek therapy. Working toward these benefits, however, requires effort on our part and a willingness to work together. It may result in your experiencing some

discomfort. Change will sometimes be easy and swift, or it may be slow and challenging and even frustrating. Remembering and resolving significant life events in therapy can

bring on strong feelings of anger, depression, fear, or other uncomfortable emotions. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally sought after. You have the right to ask questions about any of the procedures used in the course of your therapy.

**HOW TO REACH ME:** My business telephone is (425) 820-7100. I rarely answer this phone directly but check for messages several times throughout the day during the week and at least once a day on weekends. I will return your call usually within one business day. Non-urgent calls received after 3 PM on Friday will be returned on Monday. . Due to the nature of electronic communication, our e-mail exchanges are less secure than voice or written communication. Encrypted e-mail is more secure than non-encrypted e-mail. **You will need to sign the related consent at the end of this document if you want to continue to communicate with me by e-mail, once care has begun.** I will respond in the same time frame as phone calls. If you have signed an agreement for us to communicate with non-encrypted email at the end of this form, then you do not need to use the contact form.

**URGENT OR EMERGENT NEEDS:** An emergency is an unexpected event that requires immediate attention and can be a threat to your health or safety. **If your emergency is life threatening, and you need immediate care, instead call 911**. **Kirkland Psychotherapy, Inc does not respond to emergency situations**. If your situation is not an emergency, but is urgent and you feel you need to speak to me before our next appointment, please state this when you leave your message and I will return your call. Please know, this may take 12 - 24 hours for me to respond if you call me on the week end. If I have not called you back and you feel you can’t wait any longer, please call your physician or immediately go to your nearest hospital emergency room.

**CLIENT’S RIGHTS / RESPONSIBILITES**: As the client, you have certain rights and responsibilities in your care: It is your right to refuse treatment. It is your right and responsibility to choose the practitioner and treatment modality that best suits your needs.

**FEE INFORMATION AND PAYMENT POLICIES**: It is your responsibility to contact your insurance company about your coverage and costs before we begin. Kirkland Psychotherapy Inc does not do this for you. If I am on your health insurance preferred provider list your cost will be significantly discounted, usually to less than $30.00 per session after your deductible is met. If I am not a preferred provider your costs range between 30 and 50 percent of my full fee **after your out of network deductible is met.** If it turns out, for any reason, my services are not covered, then you will be responsible for payment in full. **Your costs are due as the session begins including costs related to your deductible. You must verify you have met your deductible to avoid full charge for care. You may pay by credit card, cash or check.**

My fees are:

$180.00 for a diagnostic evaluation for a 60 minute session

$125.00 for a 45-50 minute individual session

$145.00 for a 45-50 minute family/couple session

$150.00 for a 55 to 60 minute individual session

$165.00 for a 55-60 minute couple/family session

$180.00 for a 75 minute l/couple/family session

$240.00 for a 100 minute couple/family session.

**BILLING PROCEDURES** Accounts are kept and insurance billing are done by Kirkland Psychotherapy, Inc. Statements are sent the 1st week of every month **if** you owe money. If you do not pay your bill in full or by the 25th of the month, A $10.00 re- billing fee will be added to your account and your care will end with me unless otherwise agreed upon. Non-payment on your account after 3 months may result in my sending your account to collections. You will receive 1 month’s prior notice of collections via certified mail. I do not discount deductibles, co-pays nor “out of network” related fees. This is illegal.

**SLIDING SCALE FEES, PAYMENT PLANS, FINANCIAL HARDSHIP.**  **If you are in need, just ask.** Your fee or payment plan would be negotiated related to your financial situation. I will let you know if I cannot accommodate your needs and will refer you to lower cost care if need be.

**COURT APPEARANCE OR PREPERATION OF RECORDS FOR COURT:** Generally, I do not go to court to testify nor give depositions as there can be negative implications for my therapeutic relationship with you. If, however, I am required to appear in court or prepare documents for court, I charge 180.00 per hour. Travel time will also be billed.

**CANCELLATIONS AND MISSED APPOINTMENTS:** Once we begin, seeing each other on a regular and predictable basis is very important. Frequency of sessions and the predicted length of care are discussed in the treatment planning. Frequent cancellations or breaks will lead to less efficient care, making it difficult for you to achieve consistent progress. We will need to make every effort to reschedule within the same week, so your care will continue as planned. If you cancel an appointment without 24 hour notice, you will be charged the total of the fee I would have received had you come, unless your EAP benefit contract allows me to bill them for your late cancellation. You may contact me by e-mail to cancel an appointment (or to reschedule. Monday appointment cancellations must be made by Friday by 4 PM.

**OFFICE HOURS:** My office hours are from 9am – 6pm Mondays, 1 to 5pm on Tuesday, 9am to 5pm on Weds, and 10am to 6pm on Thursday. I do not have clinical availability on Friday but will return voice mail and e-mail within 24 hours. In general, you will receive at least 2 weeks’ notice of planned office closures. A copy of my hazardous road conditions policy will be made available to you as the winter season approaches.

**TELEPHONE TIME AND REPORT OR LETTER WRITING:** After 5 minutes of

telephone time, you will be charged $125.00 per hour, pro-rated, and $ 100.00 dollars per hour to write reports or letters at your request or requested on your behalf. (See above for info on court related document preparation). I cannot bill your insurance company for phone calls or report writing. Usually we can get our business done in less than 5 minutes. I do not do video therapy at this time.

**TIME OVERAGES AND SESSION LENGTH:** Sessions are generally scheduled for 45 minutes or 55 minutes. Intakes are 60 min. It is important for you to be on time and I make every effort to begin on time. If you come late, you lose the time that you missed and the session will end on time. If you come more than 15 minutes late, your session will need to be rescheduled unless previously arranged.

**YOUR MEDICAL RECORDS**: I keep electronic records (EHRs) that are protected by three user name and password combinations and meet the standards of Federal Privacy Practice requirements (HIPAA). Additionally, my computer is fully encrypted and once logged off of, can only be accessed with my password. Records are kept in electronic form only, and are stored “in the cloud.” They can only be accessed through software on my primary computer. This is the most secure place for them. E-mails may be saved in your electronic health record. If need be, your record can be printed out, but I need at least 5 working days’ notice to do this. Please see my Notice of Privacy Practices for additional information regarding the security of your record and privacy.

**CONFIDENTIALITY:** I am bound by my professional ethics to protect your right to confidentiality. Therefore, the fact that you are seeing me, as well as what we discuss in session will be held in confidence, with some limits and exceptions.

**COMMON LIMITS TO CONFIDENTIALITY**: I am a mandated reporter. I am required by law to report to the authorities’ information regarding unreported past abuse or neglect of children and dependent persons, if you pose a danger to yourself or others, or in the event of court-ordered disclosure. Protected Health Information (PHI) may also be disclosed with written authorization from you or your representative, waivered by your bringing charges, subpoena from the Secretary of Health related to complaint or report, or your communicated contemplation or commission of a crime or harmful act. Please see my Notice of Privacy Practices for details regarding the security and disclosure of your record. If records are requested for sessions with others involved, authorization will be needed from the other person(s). Otherwise, records related to others will be redacted (removed) before they are released. I make every effort to protect the privacy of our communication

**CONSULTATION AGREEMENT**: In order to give you the best care I can provide, I do formally consult with either experts in the type of care I am providing, or with clinical peers. I make every effort to conceal your identity and am very careful about checking for possible conflict of interest.

**END OF CARE:** Should you choose not to enter therapy with me, If you would like, I will provide you with names of other qualified professionals whose services you might prefer. You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

1. When I believe that therapy is no longer beneficial to you.
2. When I believe that another professional will better serve you.
3. When you have not paid for the last two sessions, unless special arrangements have been made with me.
4. When you have failed to come for your last two therapy sessions without a 24- hour notice.
5. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.

6. When you fail to cooperate with the recommended treatment.

(continued) If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision and I will give you the names of three other therapists.

As life can bring unexpected circumstance, should I be unable to continue your therapy, my trusted colleague, Shelly Burns, MA. LMHC will contact you to discuss my absence and give you other options for care if you would like.

**NOTICE TO CLIENTS:** Clients of licensed social workers in the State of Washington may file a complaint with the Department of Health any time they believe a social worker has demonstrated unprofessional conduct. Social workers practicing counseling or psychotherapy for a fee must be registered, certified or licensed with the WA State Department of Health for the protection the public health and safety. This does not include recognition of any practice standards, or necessarily imply the effectiveness of any treatment. **If you have a concern or complaint about my services, please feel free to discuss them with me. There may be a misunderstanding or question I can help with.**

You may also direct questions or complaints to:

Department of Heath

Business and Professional Administration

P.O. Box 9012

Olympia, WA 98504-800 ph: 1 (360) 753-1761

**AKNOWLEDGMENT OF OFFICE POLICIES AND CONSENT FOR TREATMENT AND INSURANCE BILLING:**

I authorize and request

Sue Moreland, MSW, LICSW to carry out diagnostic procedures, and/or provide mental health care that either now, or during the course of my care, are recommended by her. I understand Sue Moreland will bill my insurance company electronically and release necessary information to your insurance company for processing. I have read, have had the opportunity to ask questions, and fully understand this Disclosure Statement provided to me. I have been offered a copy of this document.

Date Client's Signature

Date Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIANS PLEASE NOTE LEGAL RIGHT OF REPRESENTATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date Therapist's Signature

**FEE AGREEMENT:**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_agree to pay \_\_\_\_\_\_\_\_.00 for my or my child/trustee’s full agreed upon fee or co-pay each session, I understand if I have not met my insurance deductible, I will need to pay the contracted allowed amount at the time of service until the deductible is met unless otherwise agreed upon. I understand I will be invoiced for my co-insurance once my insurance has processed my bill and that I will be charged a $10.00 re-billing fee for non-payment by the end of the billing period and my treatment will end unless otherwise agreed upon. I am contracting only to pay for therapy sessions I attend, for sessions I miss without providing required notice, for telephone time more than 5 minutes, or for administrative or report writing time. I understand and agree to the payment and billing policies as outlined in this document.

DATE\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF **CLIENT**

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PARENT/GAURDIAN

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF THERAPIST

**IF CLIENT IS A MINOR AGE 13**+:

I do / do not (circle one) assign my parent (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to act as my representative for matters of consent to disclosure of Personal Health Information:

Date: \_\_\_\_\_\_\_\_\_ Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_ Parent Rep Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_ Therapist’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE or ENCRYPTED E-MAIL:**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, ALLOW: SUE MORELAND, MSW, LICSW**

**11415 NE 128TH ST SUITE 100**

**KIRKLAND, WA 98034**

**TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE BY:**

**NON-SECURE or ENCRYPTED INTERNET MEDIA (CIRCLE ONE OR BOTH):**

**(please initial types of information you authorize communication for)**

**\_\_\_\_\_\_\_Information related to the scheduling**

**\_\_\_\_\_\_\_Information related to billing and payment**

**\_\_\_\_\_\_\_Information related to clinical care.**

This authorization will continue during the entire course of care and for purposes of communication regarding payment only after care has ended. I have been informed of the risks, including but not limited to a breach in my confidentiality regarding my care with Sue Moreland, MSW because of transmitting my protected health information by electronic means. I understand that I am not required to sign this agreement in order to receive care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Therapist