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Agreement for Behavioral Health Services and Acknowledgment of Receipt of Information

Welcome to our office. We look forward to meeting you, and do apologize for greeting you with so much paperwork. First, we ask you to carefully read and sign this agreement, and to fill out a registration sheet and a health history. We also provide you with a copy of this signed agreement to review later or for your records.

Treatment Goals: Therapy and evaluation involve working on difficult and emotional issues. Arriving at and working on the goals of treatment are the joint responsibilities of client and therapist. By the end of the intake, which may take one or several sessions, we should have discussed treatment goals. Please plan for your therapist to ask you many questions and take many notes during the intake phase of your treatment. In addition, from time to time during our work together, we will review goals and add new ones to suit your needs.

Confidentiality: The laws of the State of Washington require that most issues discussed in the course of therapy remain confidential and privileged. By law, we may release information concerning treatment or evaluation only with your own written consent. If you wish us to consult with an agency, physician, lawyer, etc. about your evaluation or treatment here, we will ask you to sign a Release of Information Form so that we can disclose this personal information to the individual(s) you select.

You need to know that the law requires us to disclose information about you, i.e., break confidentiality, under the following circumstances:

1. If we suspect child abuse;
2. If we consider you at serious risk for harming yourself or someone else. In some cases, if we believe you will harm someone else, we will break confidentiality to warn appropriate authorities and the potential victims and/or your family;
3. If we believe you pose a serious danger to yourself because of your inability to meet your basic physical and safety needs;
4. In very specific circumstances, courts or attorneys may subpoena your records or subpoena your provider to testify. If this happens, we will attempt to protect the confidentiality of the information about you to the extent that we legally can;
5. If you submit our bill for an insurance claim, or for an agency to pay, they will require information about your diagnosis, the dates, type, length of service, and fees. You may have signed an agreement to permit us to send progress notes as well. Though we will not reveal the contents of our joint therapy without your written permission, we cannot control what information you authorize your insurance company to see or what use they may make of this information;
6. If you fail to pay your bill, we will use a collection agency, or go to court to collect what you owe.

Emergency Contact: A secretary or an answering service answers the phone. They will help you to reach Dr. Nyblade in an emergency. When you urgently wish to speak with Dr. Nyblade and the office cannot reach her, for example because she is out of town, she will sometimes use the services of another therapist to provide emergency help for you. In all cases, if you should have emergency problems and are not able to reach Dr. Nyblade, please contact the Crisis Line (1-800-584-3578) or St. Joseph's Hospital Emergency Room (734-5400)

Fees and Payment: Charges for psychotherapy depend on the length of appointment. As of July 1, 2012, fees for psychotherapy are: Intake: $210, 50 minute session, $145. _____ **(Client Initials)**

In an evaluation, costs accrue for each test given based on how long it takes to administer, score, and interpret the test. You may accrue costs for report-writing time, for consultation on your behalf (for example, calling doctors or lawyers) and for lengthy phone consultation with you. We do not charge for time spent in making or changing appointments, discussing billing, or brief phone calls.

Please plan to pay any required fees (for example, co-payments, etc.) prior to each session.

Cancellations and Charges: To avoid charges, you must cancel appointments at least 24 hours in advance. We bill a partial fee for the first appointment missed that you have not cancelled 24 hours in advance. We bill the full fee, thereafter, for missed appointments. **Insurance will not reimburse you for a missed appointment.** _____ **(Client Initials)**

Insurance: Generally, we will submit bills to your insurance carrier, managed care company or EAP, and they will reimburse us for services provided to you if this is in accordance with your benefits. Please check your policy to determine what services they cover, amount of deductible, percentage paid, co-payment, and any limitations on the benefits you are allowed. The statement from our office contains the relevant information which most insurance companies require**. In all cases, though, you are fully accountable for payment and for the arrangements with your private insurance carrier.** We will try to help whenever possible. _____ **(Client Initials)**

Other treatment required: If you have been arrested for domestic abuse, whether convicted by a court, or not, the law requires treatment by a state certified treatment agency and you must inform us of the arrest—even if a court mistakenly orders treatment for "anger," marital, individual or other therapy. Similarly, if a court has convicted you of any sexual crime, you must inform us of this, whether you have received treatment or not.

Records: We keep a record of the health care services we provide you. You may ask us to see and photocopy that record (at 60 cents per page). 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. You may see your record or get more information about it by speaking to your therapist and planning a time for the review.

I acknowledge that Dr. Nyblade has provided me with access to information concerning my rights as a patient, the fees for her services, and her office policies. I further acknowledge that I have reviewed this information and had any questions adequately answered. I acknowledge that I have provided, or will provide, Dr. Nyblade with complete information concerning any domestic abuse arrests or sexual offenses, whether anyone specifically asks me for this information, or not.

I authorize Dr. Nyblade to render behavioral health services to me. My signature means that I am giving my informed consent without exception. I have read and understood this agreement and the staff has given me a copy of it. I understand my responsibility and the responsibility of the psychologist.

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Client Signature (Parent/Guardian if minor patient) **Date**

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Clinician Signature **Date**