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BERRETT
PSYCHOLOGICAL
SERVICES

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Agreement for Fees and Psychological Services

Welcome to my practice: This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of our first session. Please read it carefully and jot down any questions you might have so that we can discuss them at our first appointment. When you sign this document, it will represent an agreement between us.

My Qualification: I am a licensed Psychologist in the State of Washington. I have a Master's degree and Ph.D. in Clinical Psychology from Brigham Young University in Utah. I have specialized training in testing, evaluation, and therapy with children, adolescents, adults and families. I have worked with preschool children, school-aged children, adolescents, families and adults in private residential and outpatient treatment centers, community mental health agencies, schools, state mental hospitals, and private practice.

My theoretical orientation is dynamic, which incorporates psychoanalytical and relationship-based principals. I also utilize some behavioral interventions in dealing with dynamic issues. I have found that when treating most clients, it is useful to utilize a multi-modal approach that may include insight therapy, relaxation training, cognitive-behavioral interventions, consultation with parents, play therapy with children, and so forth. My approach in therapy is individually tailored to the client's age, personality, and specific needs.

My psychological evaluations are generally comprehensive investigating cognitive, emotional, attention, learning, and behavioral issues. An evaluation generally includes gathering of historical information, review of records, feedback questionnaires, standardized testing, and observation.

First Session: The first session is for gathering information regarding the presenting problem. During the session I may gather information regarding developmental history, school performance, social relationships, family dynamics, health issues, emotional/psychological/behavioral symptoms, and so forth to provide background for primary concerns. Please bring documents such as previous testing, school reports, medical records, etc. that you believe may be helpful in discussing important history.

Services: I provide individual therapy, psychological evaluations, parenting training, and family counseling. I cannot guarantee a particular treatment outcome; successful treatment and/or evaluation is dependent upon the mutual effort of both client and therapist. I can, however, assure you that I will use my skill and training to the fullest extent to identify and/or resolve the problems for which you sought treatment. You are, of course, free to discontinue treatment at any time. I can refer you to others in the community or the Washington State Psychological Association (425-712-1852) will provide names of therapists in the area. Should you choose to discontinue services, you will still be responsible for payment of services that have already been provided. You should be aware that discontinuing services may result in

loss of other services or the creation of other problems, such as answering to The Court or GAL if services were court ordered or recommended by GAL.

Psychotherapy can have risks and benefits. Since therapy often involves discussing unpleasant aspects of one's life, children and adults may feel uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Some clients "act out" these feelings particularly in the early stages of therapy. Psychotherapy has also been shown to have benefits for people who go through this process. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. A therapist's goal is to support and contain a client's emotions and provide a therapeutic environment in which the client can process through feelings and experiences.

My Business: I am an independent practitioner renting office space at Sunridge Professional Center. I am a separate, independent business entity under the name of Berrett Psychological Services, Inc. and am independently licensed and insured.

Communication: I have full time office scheduler during business hours to schedule appointments and take non-confidential messages (425-318-0062). For lengthy or confidential messages, please email me at kristine@berrett.com. In the event of an emergency and I cannot be reached, please call the Care Crisis Clinic (425-258-4357), which can be dialed collect if necessary or dial 911.

Appointments: Appointments are scheduled for 50 minutes for counseling, intake, and evaluation feedback sessions. Face-to-face testing appointments are generally scheduled for an hour and 50 minutes. Please arrive on time for appointments and wait in the waiting room (suite 300). If you arrive late for an appointment, the lost time will be part of your scheduled time. **In the event you cannot keep an appointment for any reason, please give at least 48 hours notice of cancellations, otherwise you will be charged the full fee for the time I have reserved for you.** If you or your child are ill and contagious or have a temperature, please do not come to the office.

Fees: The fee for therapy sessions is $150 per 50 minute session and the initial intake session is $250 for the session. Evaluations are charged $200 for each hour spent administering and scoring tests, writing reports, and providing feedback. Payment can be made in cash, money order, or check. Checks can be written to BPS (Berrett Psychological Services) or me (Kristine Berrett). ***Payment in full is due at the time of the session*** and you may pay me directly. If you are using health insurance for payment, you are responsible for payment of any co-pay or patient responsibility at the time of each session. **Failure to pay your fees may result in suspension or discontinuation of services.**

Routine calls under 10 minutes, time spent scheduling appointments, and billing will not be billed to you. Telephone consultation or email with you or with professionals such as teachers, physicians, or other therapists, will be billed at the usual office rate of $50 per 15 minutes. After hours phone consultations (after 5:30 PM or on weekends) are billed at $250 per session. Time spent reviewing records, preparing correspondence or reports, and scoring psychological testing, will be billed at the usual office rate of $200 per hour. Any intake testing not covered by insurance will also be billed to you.

Legal work, such as consultation and similar work for attorneys, preparing reports, affidavits, declarations, reviewing records for court, and court testimony (including time spent traveling and waiting to testify) will be billed at my legal rate of $300 per hour.

If, for any reason, an unpaid balance remains after 30 days, **a finance charge of 1 ½ % per month** will be applied to the unpaid balance. If your account has not been paid for 60 days, I have the option of using legal means to secure payment. This may involve hiring a **collection agency or going through small claims court**. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the service provided, and the amount due.

Any checks returned for insufficient funds will be charged $35 plus a $10 processing fee. If your credit card is declined, you will be charged a $10 processing fee.

Insurance: Many insurance plans cover outpatient mental health services. **It is your responsibility to check with your insurance carrier for specific information regarding your coverage.** Please inform me or my billing service regarding the type of insurance you have, as each plan is somewhat different in the amount the patient has to pay per visit, the number of visits covered, and the type of billing required. Our office will bill your primary insurance directly. **Co-pays and patient responsibility are due at the time of service.** It is your responsibility to determine what your co-pay or patient responsibility is. Please be aware that authorization for treatment by your insurance carrier does not insure payment to a provider. If you insurance carrier refuses payment for any reason, **you are responsible for your bill**.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

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 your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

My billing service is Fountaingate Billing (877-651-8100). Brandi Goellner is the billing agent. This service maintains my billing records, bills insurance companies, and sends you your monthly statements. Payments of any account balances reflected on your monthly statement is to be made directly to me at my billing address. A mailing envelope will be provided to you with your monthly statement.

Fees paid for mental health and psychological services may be tax deductible as a medical expense if you itemize your deductions. You may also deduct your transportation costs to and from the office per visit. Check with your accountant or tax consultant.

Minors: Parents of children under the age of 18 years have the right to examine treatment records. It is my policy to provide only general information to parents of children age 13-17 about our work together. I feel that a child must feel a degree of confidentiality in order to develop a therapeutic alliance with a therapist and confide in the therapist. Even a younger child will feel distrust if a parent questions the therapist or child about specifics of what they talked about or what the child reported to the therapist. I would of course report any risk that a child might harm him or herself or another. I encourage children to report other significant information to a parent when appropriate, and this may occur in the form of a joint session with the parent and child. I will also provide parents with a written summary of treatment when it is complete, if it is requested. Before giving this information, I will discuss the matter with the teenager and do my best to handle any objections they might have.

Divorce & Parenting Plans: My ethical guidelines indicate that I must involve both parents of my work with their children, as appropriate. If you are divorced or you otherwise have a parenting plan that concerns your child, I will require a copy of the parenting plan to review before I see the child. Most parenting plans call for joint decision making regarding medical treatment. This means that I will require

consent from both parents in order to treat your child. In cases where medical decision making lies with one parent, I will still attempt to contact the other parent to inform them of my work with your child and request that they participate in some appropriate fashion in treatment, such as providing input or feedback to me. Only when parental rights are terminated or The Court has specifically ordered that a parent may not be involved in treatment would I not contact a child's parent regarding the child's treatment.

Waiting Room Policies: Please wait for your appointment in the waiting room (suite 300). I ask you to follow the policies of the waiting room, including no food and drink and no unattended children in the waiting room. Please do not bring sick children to the waiting area. If you plan to speak to me during session time without your child present, you will need to make arrangements to have your child supervised in the waiting room.

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or

physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

- **Health Oversight:** If the Washington Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will send you this information via mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 425-318-0062.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to me, Dr. Kristine Berrett at PMB 571, 3020 Issaquah Pine Lake Road, Sammamish, WA 98075.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

This authorization constitutes informed consent without exception.

Client name:_____

Signed:_____

Parent signature if client is child:_____

Date:_____