



5700 23rd Drive West, Everett, WA 98203
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INFORMED CONSENT

Thank you for choosing our therapy services. Today's appointment will take approximately 45 to 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Our policies are designed to protect your right to privacy. Both your verbal communication with Dr. Sullivan and your clinical records are strictly confidential. Your records at this office will be stored in a locked file cabinet. However, **Exceptions** to this include: a) since Dr. Sullivan believes in a holistic approach which integrates your care with other health care providers and your child's school, she may ask you to sign a release of information to exchange information, communicate and work effectively with your Primary Care Physician, Psychiatrist, and School; b) minimal information (diagnosis and dates of service) shared with your insurance company in order to process your claims; c) if we receive information which indicates the physical or sexual abuse of a minor, then, by Washington State Law, I am obligated to report this to the Department of Children and Family Services; d) where you sign a release of information to have specific information shared or received; e) if you provide information that informs me that you are in danger of harming yourself or others; f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Dr. Sullivan will follow those emergency services with standard counseling and support to the client or the client's family.

My signature below indicates that I have understood the paragraph "Confidentiality and Emergency Situations" and that I have been given a copy and understand the "HIPAA Notice Form: Notice of Policies and Practices to Protect the Privacy of Your Health Information".

Signature(s) _____ Date: _____

FINANCIAL/INSURANCE ISSUES: We ask that you pay for services each session. Cash or personal checks are accepted. At this point in time, credit cards are not accepted. Returned checks will result in an additional charge. **If you are using insurance**, as a courtesy, at the end of each month, we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. You will then be reimbursed by your insurance company for the amount per session covered by your policy. In the event you have not met your deductible, the insurance company will not reimburse you until the deductible is satisfied. The office will need a copy of your Insurance Card and we will discuss procedures for contacting your insurance company to determine the nature of your policy (i.e. the amount per session covered, what you will be personally responsible for, and the number of sessions allowed per year). We recognize that unforeseen circumstances may result in an occasional inability to pay at the time of service. However, you may not carry a balance with this office in excess of \$250.00. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. It is this office's policy to bill your insurance so that you will be reimbursed by them. Under special circumstances, if we must bill your insurance and accept payment, we will require you to authorize payment of insurance benefits directly to Lisa Sullivan, Psy.D.

I have received a copy of the fee schedule _____ (please initial)

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. **You may have a copy of this form if requested.**

Signature(s) _____ Date _____

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your child's primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.** If you prefer to decline consent no information will be shared.

___ You may inform my physician(s) ___ I decline to inform my physician

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

___ You may inform my psychiatrist ___ I decline to inform my psychiatrist

Psychiatrist's Name: _____

Psychiatrist's Address: _____

Psychiatrist's Phone Number: _____

You will be given official release of information forms to sign for those individuals you agree to disclose to.

Signature(s) _____ *Date* _____

Client Responsibilities

1) In the event of an emergency, Dr. Sullivan will make every attempt to be available to you via her cell phone as quickly as possible. In the event that you are unable to reach Dr. Sullivan quickly in an emergency situation, please call 911 and they will assist you with an appropriate referral or intervention. Dr. Sullivan will follow up on this once she has been contacted. In non emergency situations, please feel free to leave voice mail messages for Dr. Sullivan.

2) Dr. Sullivan requests that you arrive on time for each appointment. If you are unable to make a scheduled appointment, you are asked to give an hour notice so that she can make effective use of the scheduled hour. She will make an attempt to reschedule your appointment for the same week. "No shows" or "late cancellations" (less than 24 hour notice) will be charged the full amount for the session. (Note, your insurance will not be billed for missed sessions - so you will not be reimbursed for a missed session by them).

3) It is your decision and right to withdraw from therapy at any point. However, Dr. Sullivan does request that you discuss this with her so that there can be an appropriate ending and to make referrals if you desire. Should you decide to end therapy, you remain financially responsible for services already rendered.

4) This space is provided for any additional ideas or requests you would like to have considered or added as part of our working agreement:

Therapist’s Responsibilities and Duties

- 1) Dr. Sullivan will be on time for each scheduled appointment. Sessions last between 45 and 50 minutes. Should Dr. Sullivan be unable to meet with you, she will give you 24 hour notice - with the exception of unforeseen emergencies. In that event, she will make every effort to contact you as soon as possible and offer to reschedule for that week if you desire.
- 2) Dr. Sullivan will at all times act in professional manner and in accordance with the ethical and professional guidelines set up by the American Counseling Association and the American Mental Health Counselor’s Association - in addition to following all state and federal guidelines and laws concerning her profession.
- 3) Should your care involve coordination with other health professionals, Dr. Sullivan will communicate and work collaboratively with these professionals in your best interest.

Voluntary Consent

I hereby state that I have read the entire Informed Consent provided by Dr. Lisa Sullivan or that it has been read to me. I certify that I understand and will act in accordance with its contents. If I have questions, I agree to address them today and in the future. My signature below indicates that I freely agree to participate in therapy at this time.

Clients Name (Please Print)

Client Signature

Date

I have given the client a copy of this informed consent and in my best judgment believe he/she understands the contents of the agreement and consent and has freely communicated intent to participate in therapy at this time.

Dr. Lisa Sullivan, Psy.D.

Today’s Date: