

Diedra L. Clay, Psy.D.
Clinical Psychologist

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Disclosure Statement and Treatment Agreement

As a new client considering psychotherapy for yourself or your child, you have the right to know something about my background and qualifications, and to know what to expect from our work together. Please read this document carefully so that you can make an informed decision about using my services. If, after reading this introduction, you have further questions, please do not hesitate to ask them when we meet. Once you sign this form, it will constitute a binding agreement between us.

Parties to the Professional Relationship: The professionals in this office building share only the physical facilities of this office. Each of our practices is separate and independent from one another. Therefore, your professional relationship is entirely between yourself and Diedra L. Clay, Psy.D., a licensed psychologist practicing independently.

Qualifications: I am a Clinical Psychologist (#PY00002708), Mental Health Counselor (#LH00007408) and Chemical Dependency Professional (#CP00000182) with independent licenses to practice in the State of Washington. I am also a Nationally Certified Counselor (#78231) and a Washington State Certified Chemical Dependency Counselor II (#CB00019127). I received my bachelor's degree *cum laude* in Philosophy from *Seattle University* (1991), a licentiate degree *cum fructu* in Philosophy from the *Catholic University of Leuven* Belgium (1996), and my master's (2000) and doctoral (2001) degrees in Clinical Psychology from the *Washington School of Professional Psychology*. I completed three years of pre-doctoral practicum and internship training and one year of post-doctoral fellowship training. Since completing my training, I have worked in a variety of capacities, including teaching, supervising other therapists, and doing clinical work in mental health agencies, community colleges, state prisons, and in private practice. I have been working in the field since 1989.

Psychological Services: My orientation to the practice of psychotherapy is integrative, where I use a wide variety of techniques to help clients reach their goals. Primarily, I work from an intersubjective framework, which focuses on the relationship between the psychotherapist and client as a collaborative vehicle that requires high participation on both fronts. I believe that each person is the best resource for insight and change, with my role as a guide to assist clients in discovering their own answers in a safe environment. Depending upon your needs and goals, we will develop a therapeutic strategy which may take a variable length of time. I may not be the psychologist most suited to assist you; in that case, I will do my best to provide you with an appropriate referral. Please don't hesitate to ask me if you have any questions or concerns about our work together. Please note: I occasionally will have my dog kenneled in the office, so please inform me if this is problematic for you or your family.

Confidentiality: A fundamental part of our therapeutic contract is confidentiality, an understanding that whatever you tell me will not be revealed to anyone else, unless you

specifically authorize me in writing to do so. I sometimes seek consultation with other mental health professionals regarding clients I am currently treating. In these consultations I do not give out any identifying information. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together.

There are rare exceptions to confidentiality that you should be aware of. Unless it is impossible to do so, I will always discuss a report I am required to make with you before making it. I may be required by law to make a report to the Department of Social and Health Services or a law-enforcement agency if I learn about:

- The abuse of a child or vulnerable adult;
- Potential suicidal behavior;
- If I believe a client is not able to take care of her/his basic needs;
- Threat of harm to another;
- A court subpoena; or
- If a client becomes aware that she/he has AIDS or has become HIV-positive and she/he refuses to be under medical care.

Professional Records: Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to view and/or receive a copy of your records. If you wish to see your records at any point, I recommend that you review them in my presence so that we can discuss the contents. I charge my standard hourly fee for any preparation time required to comply with an information request.

- No more than \$1.02 per page for the first 30 pages
- No more than .78 per page for all additional pages
- A \$23 clerical fee may be charged for searching and handling

Your record will not be disclosed to others unless you direct me to do so in writing, or unless the law authorizes or compels me to do so. If you have managed care coverage, your insurance carrier may also require your authorization to release information for utilization review. Please note, I cannot guarantee the extent of confidentiality of your records once they have been released from your file. This office is compliant with federal HIPAA rules for the privacy of personal health information (PHI). This means I will disclose the minimum necessary information to required entities for payment or other administrative services.

Appointments: My normal practice is to conduct a consultation that will last from 2 to 4 sessions. During this time we can decide whether I am the best person to provide the services that you need in order to meet your goals. Appointments are 45 minutes in length once per week or more frequently. Extended sessions are also available. **Once we agree to work together, I reserve a weekly appointment time or times specifically for you. Once a regular appointment time is reserved for you, you will be charged for any appointments that you miss altogether ("no shows") or that you cancel with less than 48 hours notice.** Missed appointments will be charged at your full fee. Please note that insurance will not pay for missed appointments, so you will be responsible for paying for any missed appointment charges. Please provide as much notice as possible regarding sessions that you will need to miss; in such instances, we will try to reschedule your appointment, as our schedules allow.

Couples, please note that my approach to couple therapy necessitates that both members of the couple attend every session, and be informed of all information discussed in each session. If only one member of a couple shows up for an appointment, I will not meet with her or him individually. Therefore, if one of you does not show up for any appointment, it will be considered a missed appointment and you will be charged accordingly.

For existing clients, your regular weekly appointment time is: _____

Professional Fees:

Initial Intake session	\$195.00
Psychotherapy session	\$155.00
Clinical Supervision	\$155.00
Legal preparation and attendance	\$200.00 per hour
Psychological Testing	\$ varies depending upon testing instruments
EAP referral	Hourly charge based on your EAP contract

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require, such as report writing, telephone conversations that last longer than 15 minutes, consultations with other professionals that you have authorized and requested, preparation of records or treatment summaries, or the time required to perform other services that may arise in the context of your treatment. If psychological testing is requested, I will discuss the specific charges, given the tests selected. Reports are released upon payment in full for the services provided. If you become involved in litigation that requires my participation, you will be responsible for paying for the extra professional time required, because of the complexity and difficulty of legal involvement.

Billing and Payments: Payment is due at the time of service, unless other arrangements have been made. Your insurance may reimburse you for a portion of the cost of services, and you may use your monthly statement to submit a claim to your insurance company. While I will gladly submit an insurance claim on your behalf when I am a preferred provider for your insurance carrier, you remain responsible for the payment of your bill. **It is your responsibility to determine what your benefits are, any requirements for pre-authorization for services, copayments that are required, and whether I am an eligible provider.** If your insurance will not cover my services because I am not on their panel, you may choose to pay for sessions yourself, or to see another therapist who is on their panel. I will provide you with any assistance I can in facilitating your receipt of the insurance benefits to which you are entitled. However, you, and not your insurance company, are responsible for full payment of the fee to which we have agreed. Therefore, it is very important that you find out exactly which mental health services your insurance policy covers.

Accounts more than 30 days overdue will accrue interest charges at a rate of 1.5% per month. If your account becomes more than 60 days past due, and suitable arrangements for payment have not been agreed to, I may need to use legal means to secure payment, including collection agencies or small claims court. In most cases, the information I would release about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

Contacting Me: I am often not immediately available by telephone. When I am with clients or out of the office, my phone is answered by my answering machine, which I monitor frequently. I will make every effort to return your call on the same day you make it, **with the exception of vacations, weekends and holidays, or at night.** If you cannot reach me, and you feel that you cannot wait for me to return your call, you should contact:

- **the Crisis Clinic at (206) 461-3222,**
- **call 911, or**
- **proceed immediately to the nearest emergency room.**

If I am unavailable for an extended period of time (i.e., a vacation), I will provide you with the name of a trusted licensed colleague whom you may contact if necessary.

Ethics and Professional Standards: I abide by the ethical, professional, and legal standards established by the *American Psychological Association* and the State of Washington. At any time, you may ask me to discuss my treatment approach. Please be aware that you have the right to request a change in treatment, referral to another therapist, or other resources, and/or to refuse treatment or discontinue our work together. I will make appropriate referrals if I become aware of a problem that is outside of my area of expertise.

Finally, it is important that you know that you have recourse available if you feel that I have acted unprofessionally or have caused you harm. If you believe that I have acted unethically in our work together, please contact:

Department of Health
Examining Board of Psychology
P.O. Box 47868
Olympia, WA 98504-7868
Telephone 360-753-2147

As a result of new state regulations adopted by the Washington State Department of Health, I am required to report myself or another health care provider in the event of a final determination of an act of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have knowledge of unprofessional conduct by another licensed provider. I will also have to report a patient who is a health care provider who may pose a clear and present danger to his/her patients, clients. If you have any questions or concerns about this requirement, please discuss them with me.

Please provide credit card information for missed appointments:

Card type: _____

Name on card: _____

Card number: _____

Expiration date: _____ Security code: _____

Statement of Agreement Regarding Fees and Services - Consent: Your signatures below indicate that you have read the information included in this document and agree to abide by it during our professional relationship.

- A. I have read Dr. Clay's policies and my responsibilities as a client, fee for service, confidentiality, qualification methods, supervision and treatment of concerns and complaints. I have had the opportunity to ask questions and discuss them, and give my informed consent for services. I have received a copy of this agreement. I agree to abide by the terms therein.

Client Signature Date

Dr. Clay Date

Spouse/Parent or Guardian Signature Date

- B. **Please sign below if you elect to self-pay rather than use your insurance.** By signing below I indicate that I do not wish to have my insurance billed and will be personally responsible for payment in full for treatment provided by Dr. Clay.

Client Signature Date

Dr. Clay Date

Spouse/Parent or Guardian Signature Date

- C. **Please sign below if you intend to seek reimbursement from your insurance company.** I permit Dr. Clay to release information necessary for billing purposes, managed care utilization review, and coverage by my insurance company. This may include symptoms, diagnoses, dates of office visits, type(s) of service provided, fees, and other information required by the insurance company. I further authorize payment of the claim directly to Diedra L. Clay, Psy.D. This authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize Dr. Clay to release all information necessary to secure payment. If my insurance will not authorize payment of services, I understand that I am financially responsible for all charges.

Client Signature Date

Dr. Clay Date

Spouse/Parent or Guardian Signature Date

- D. **Cancellation Policy** I understand that I will be charged my full hourly fee for any appointments that I miss with less than 48 hours notice, via the credit card information I provide on this form. In addition, if I am a member of a couple, I agree to pay for any sessions that one or both members of the couple miss.

Client Signature Date

Dr. Clay Date

Spouse/Parent or Guardian Signature Date