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LICENSED CLINICAL PSYCHOLOGIST
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Consent for Treatment and Office Policies

The following information is being provided to you so that you can make an informed decision about whether or not to enter into a therapeutic relationship with me. It also provides information regarding your legal rights and responsibilities. Please feel free to bring up any questions or concerns you may have regarding this information at any time. Signing this document represents a professional agreement between us.

Professional Qualifications

I am a licensed clinical psychologist in Washington State (PY 60537866). My graduate training in psychology was completed at Rosemead School of Psychology at Biola University in La Mirada, California. I hold both a masters and a doctorate in Clinical Psychology. As a part of my training and experience, I have worked in outpatient clinics, college counseling centers, and community mental health centers. Both my graduate school training and my internship experience were completed at institutions accredited by the American Psychological Association (APA). I am a member of the American Psychological Association (APA) and abide by its code of ethical conduct for psychologists.

My clinical experience includes therapy and assessment work with individuals, couples, families, and groups. I have been trained in several modalities of therapy including psychodynamic treatment, emotion-focused therapy (EFT), cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), and short-term, relationally focused therapy. I work with clients of all genders, religions, and sexual orientations.

The Therapeutic Process

In our first session, we will discuss the reasons you are seeking treatment and clarify your goals for therapy. I will also inform you of procedural information and give you an opportunity to ask me questions and decide if you feel comfortable working with me. If you choose to move forward, we will discuss a course of treatment including a potential time line for therapy. If at any time you feel we are not a good match for treatment, I am happy to discuss other options and provide you with alternate referrals.

The therapeutic process requires trust, openness, collaboration, and a commitment to change. Change is gradual and requires commitment and hard work, and psychotherapy includes both benefits and risks. As therapy involves talking about difficult aspects of your life, you may experience a variety of intense and stressful feelings and emotions such as sadness, anger, anxiety, guilt, loneliness, betrayal, or hopelessness. However, research has also documented many positive benefits such as increasing self-awareness, more satisfying relationships, solutions to specific problems, and significant reductions in feelings of distress.

Contacting Me
I am available via phone (360) 519-4080 or email at info@heatherjacobsonphd.com; however, please note that I use email **only** for scheduling or administrative purposes. Please do not email me with private information regarding your treatment, as I cannot guarantee your confidentiality via email. If you leave me a voice mail, I will respond to your call by the next business day; I return weekend messages on the following Monday. In an emergency, please call 9-1-1 or go to the nearest emergency room.

Social Media Policy
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and may also blur the boundaries of our therapeutic relationship. If you have questions about this, please let me know. Please do not use mobile phone text messaging or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Please do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Confidentiality
All therapeutic information is privileged and confidential except for legally mandatory reporting laws which apply to very specific situations. For example, in an emergency, I may speak to another healthcare provider or your emergency contact. I may only release information about our work to others if you sign a written Authorization Form that meets certain legal requirements imposed by state law and/or HIPAA.

Instances in which I may disclose information without your consent are described below
➢If I have good reason to believe that you will harm another person I am legally bound to attempt to inform that person and warn them of your intentions. I must also contact local law enforcement.
➢If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about somebody else who is doing this, I must inform local authorities.
➢If I have good reason that you are in imminent danger of harming yourself, I may inform authorities.

I sometimes find it helpful to consult other professionals about a patient's treatment. When I do so, I do not reveal the identity of the patient, and the consultant is also legally bound to keep any information confidential. Unless you object, I will not inform you about these consultations unless I feel that it is important to our work together. I will note all consultations in your clinical record.

If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without 1) your written authorization; 2) you informing me that you are seeking a protective order against my compliance with a subpoena that has been properly served on me and of which you have been notified in a timely manner; or 3) a court order/subpoena requiring the disclosure. If you are involved in or contemplating litigation, you should consult with your attorney about likely required court disclosures. There are some situations where I am permitted or required to disclose information without either your consent or authorization:

If a government agency is requesting the information for health oversight activities, I may be required to provide it.

If you file a complaint or lawsuit against me, I may have to disclose relevant information regarding our work in order to defend myself.

If you file a worker's compensation claim, and the services I am providing are relevant to the injury for which the claim was made, I must, upon appropriate request, provide a copy of your record to your employer and the Department of Labor and Industries.

Sometimes, disclosures are required by health insurers or to collect overdue fees.

If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Please let me know if you have any questions or concerns regarding these policies.

Fees and Billing

My fee is $180 for the initial session. For following sessions my fee is $160 per individual session or contracted insurance negotiated rate. Payment is due at the beginning of each session, and it is your responsibility to pay for all services rendered. I am not willing to have clients to run up a bill; if you encounter difficulty paying for your sessions, please discuss it with me. If your account has not been paid for more than 90 days and you have not made any arrangements with me for payment, I have the option to use legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs incurred will be included in the claim.

Telephone sessions, consultations with physicians, attorneys, etc., report preparation, and any other relevant services will be billed at a proportionate rate of my hourly fee. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

Cancellation Policy

Our scheduled appointment times are reserved for you; sessions typically last 45-50 minutes. If you cannot make a previously agreed upon session time please let me know as soon as possible

within 24 hours of our session. If you do not cancel within 24 hours of a session and it is not an emergency, you will be responsible for your hourly fee and this will not be covered by insurance.

If I plan to be out of the office for an extended period of time, I will discuss alternate treatment options with you.

Insurance
I accept insurance plans with which I am credentialed and have negotiated an hourly fee. Whatever they do not pay is your responsibility (this includes deductibles and co-pays). If you provide me with your insurance information, I will submit a claim to your insurance company. If you require additional documentation, I will be glad to provide it, but please keep in mind that I cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Please be sure to read your benefits booklet and consult your insurance plan administrator about the limits and terms of your coverage.

Please be aware that your contract with your health insurance company requires that I share with them 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. By signing this agreement, you are permitting me to provide requested information to your insurance carrier.

Complaints
If you feel that I have acted unethically and/or unprofessionally you have the right to submit a complaint against my license to the following: Examining Board for Psychology, Dept. of Health, PO Box 4789, Olympia, WA 98504

Forensic Services Billing Policy
You understand that if I am subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying me at the rate of $200 per hour for all time expended on preparation, waiting at court, transportation, and testimony. Please note that this rate is higher than my hourly fee due to added legal expenses.

Professional Records
You should be aware that, pursuant to HIPAA, I keep information about you in your Clinical Record. It includes 1) a record of your sessions with cursory information about your diagnosis, symptoms, and general functioning, as well as your goals, your progress, and the interventions we have used; and 2) any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that I have sent to anyone; including reports to your insurance carrier. If you request it in writing, you may examine and/or receive a copy of your Clinical Record, (except in the unusual circumstance that I conclude disclosure could reasonably be expected to cause harm. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

Client's Rights
Finally, you have the right to revoke this agreement in writing at any time. That revocation will be binding on me unless 1) I have taken action in reliance on it, 2) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or 3) you have not satisfied any financial obligations you have incurred.

Your signature below indicates that you have read this document and agree to its terms.

_____	_____
Client signature	Date
_____	_____
Therapist's signature	Date