Anne Wright, PhD, PLLC
Child & Adolescent Assessment

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TERMS OF SERVICE & CONSENT TO TREATMENT

I am pleased that you have selected me as your psychologist. This document contains information about my professional services, business policies and our professional relationship. While this document may seem lengthy, I request that you review it thoroughly. As you will be investing your time and resources in our work together, it is important for you to be familiar with these policies.

ASSESSMENT/TREATMENT

My practice focuses predominantly on psychological assessment for children, adolescents, and young adults. I may also provide consultation services and initial therapeutic recommendations, but I do not provide any ongoing therapy or intervention at this time.

The psychologist-client relationship for assessment and testing services differs from a therapeutic relationship. First, in general, we will work together only briefly. The assessment process typically consists of four sessions—an initial interview, two testing sessions of up to three hours each, and a feedback session. Assessment and testing is individualized and thus the length and number of testing appointments may differ from this scenario. In the feedback session you are generally presented with the findings, diagnostic impressions and recommendations. The feedback session may occur several weeks prior to the completion of the written report. Second, given that you are furnished with a written report, issues around confidentiality are also somewhat different than they are in a therapeutic relationship. Information that you or your child disclosed in an interview may appear in the report. Confidentiality is reviewed more below; however, it is important to emphasize that questions regarding confidentiality can be addressed at any time. Please be aware that in addition to our face-to-face meetings I also bill for the time it takes to write the report. In general, you will be provided with one copy of the report and reports can be sent to any other professionals for whom I have a valid release. There is a service fee for additional copies, including electronic copies, of your child's report.

While we will be discussing personal issues it is important to remember that our relationship is professional rather than personal. Professional ethics require that our contact be limited to the sessions you have with me. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

CONFIDENTIALITY AND PRIVACY

Within the limitations discussed below, the information that you or your child reveals to me during our professional relationship will be kept confidential and will not be released to anyone without your written consent. If your child is age thirteen or older, they also must provide written consent for the release of information. By law I am required to report actual or suspected child or elder abuse to the appropriate authorities. I am also legally bound to protect anyone you or your child might threaten with violence, physical harm or other dangerous actions, including yourself. If a legitimate court order is issued, or this service is ordered by or under the supervision of the court, I am obligated to share information with court appointed authorities. Further, insurance or managed care companies require you to consent to release of records and/or information to them as a condition for reimbursement. If I will be filing insurance claims for you, your signature(s) below on this document indicates your permission for the release of any and all information as required by the insurance or managed care company.

Good clinical practice requires occasional peer review and consultation. Please be aware that your child's case may be clinically reviewed with other mental health professionals and every effort will be made to preserve your child's and family's confidentiality during these consultations. Additionally, if needed, other professionals may provide clinical coverage when I am out of town, or in an emergency, and thus some information may be shared with them so they will be better prepared to assist during any of my absences if necessary.

If I will be working primarily with your child or adolescent, I will use my clinical judgment to determine what information will be kept private in addition to the limitations to confidentiality outlined above. We will discuss the confidentiality of therapy for minors, and the law in Washington State, in greater depth when we meet.

FEES AND PAYMENT

Unless otherwise arranged with me, effective July 1, 2018, my fees are as follows:

Initial Interview	$225
Psychological, Neuropsychological, & Academic Testing	$87.50/per half hour
Report Writing	$175/per hour
Feedback Appointment	$175/per hour
Court Testimony	$350/per hour
Court Preparation	$150/per hour
Record Review	$175/per hour

Telephone consultations that exceed 10 minutes will be charged at the hourly rate in quarter-hour increments. Out-of-office appointments including treatment coordination with other professionals will be charged $150.00 per hour.

Fees for service are due at the time the service is provided if you are paying privately, or if the service is not covered by the insurance company. I do not accept credit cards at this time. Payments thru PayPal are accepted. Please make your checks and money orders payable to Anne Wright, PhD. Checks returned by your bank for non-sufficient funds [NSF] will result in a $35.00 fee. My office bills monthly and prompt payment is appreciated. If your account is more than 90 days overdue, interest will accrue and the account may be sent out of the office for further collection.

Office visit co-pays are your responsibility and are due at the time of service. My office will bill insurance companies I am contracted with directly for their portion of the covered services. If I am not contracted with your insurance, my office will provide you with all necessary documentation so you can submit claims directly to your insurance. It is your responsibility to know the specifics of your insurance coverage as well as procuring any relevant paperwork that is required by your insurance company.

Please note that as the recipient of services, or as the responsible party for the recipient of services, you are responsible for all charges not paid for by your insurance company. Payments will be due at the time the insurance company notifies my office of any unpaid portion.

All insurance companies require that I diagnose a mental health condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before submitting it to the insurance carrier. Also, some insurers require that I coordinate care with your primary care physician and/or a behavioral health care manager. If you have any questions about the details of your plan, please refer to your benefits booklet or contact your insurer.

CANCELLATIONS

I recognize that emergencies may preclude you or your child from attending. If you are notifying me of a cancellation or are requesting an appointment change less than 48 hours before the scheduled appointment, please notify me via telephone at 360-961-8766**.** For rescheduling requests further in advance, you may call or email me at anne@drannew.com.

Due to the number of hours that are reserved for testing appointments, **if any testing appointment, including the initial assessment, is cancelled with less than 72 hour notice, you will be billed a $100 fee.** Please be aware that my office does not make reminder calls for appointments.

For feedback appointments, 24 hour notice is required for cancelled sessions. Unless 24 hour notice is given, you will be expected to pay in full for a missed appointment. Your insurance cannot be billed for missed sessions, and insurance will not pay for missed sessions.

EMERGENCIES/CONTACTING ME

Messages can be left on my confidential voicemail at any time: (**360) 961-8766**. Except in case of emergency, I will make every effort to return your call by the next business day. Also, please remember to leave your contact number with every message. If a contact of more than 10 minutes is necessary, a fee will be charged at the individual hourly rate in quarter-hour increments. Please do not use email to contact me about any issues that arise within 24 hours of your appointment or for issues that require a prompt response. I do not check email after 5pm or during the weekends.

In an emergency situation you may call me directly at **(360) 961-8766.** However, if I am unable to reach you as quickly as you require or in the case of a life-threatening emergency, please call **911** or go to the Emergency Room, or call the 24-hour Crisis Line at **1-800-584-3578.**

COMPLAINTS

If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Examining Board of Psychology, Department of Health, PO Box 47869, Olympia, WA, 98054, or call them at (360) 236-4928.

By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure statement. I also give Anne Wright, PhD, PLLC, my permission to release to my insurance company any medical or other information necessary to receive payment for her services.

Client Name: _____

_____ _____
Client Signature (age 13 or over) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

Please read the attached Notice of Privacy Practices for more information about your privacy rights. Initial here to acknowledge that you received a copy of the Notice: _____