PEDIATRIC and ADULT PSYCHOLOGY

ASSOCIATES, L­­LC

**Office Policy and Privacy Practices**

An Office Association of Independently Practicing, Independently Licensed Mental Health Professionals.  This statement explains my fees, services, procedures, therapeutic approach, your rights as client, and outlines my education, training, and experience.  Your questions are very important to me, so please ask for clarification or further information if needed.

**EDUCATIONAL BACKGROUND AND EXPERIENCE: I hold two bachelor of arts degrees in child psychology and special education, a masters degree in reading instruction, and school administrative credentials, all from Western Washington University, and a doctoral degree in clinical psychology from the Union Institute, in Cincinnati, Ohio.  I am licensed in Psychology in the State of Washington (#2602).  I was a special and regular education teacher at the elementary and junior high school level for ten years, an elementary school counselor for ten years, and an elementary school principal for five years.  My internship, at Madigan Army Medical Center, and post-doctoral training, at Pediatric Psychology Associates, focused on a specialty in pediatric psychology.  I have been an adjunct professor at Seattle Pacific University teaching educational, psychological and parenting classes in Thurston County for 12 years.**

**SERVICES AVAILABLE: My practice primarily includes child therapy; however, I also offer adult individual, family, and marital therapies when called for in a particular case.  I also consult with local schools regarding cases including educational issues.  If you desire additional information about my professional experience and training, a copy of my resume is available upon request.**

**THEORETICAL ORIENTATION: As a pediatric clinical psychologist I am trained to psychologically evaluate, diagnose, and develop treatment plans for children and adults.  I am also trained and certified in Reality therapy and Choice theory from the William Glasser Institute.  The most important part of this therapy is the development of a strong professional relationship between the therapist and the client.  With a strong professional relationship the client will feel safe enough to evaluate their choices they are making that are not satisfying their needs for love and belonging, freedom, fun, and feeling valued.  I will discuss what you are doing and thinking in order to get your needs met.  Clients will learn how to expand their understanding of how much control they have in their lives without expecting others to change.  Clients often express they begin to make changes in their lives soon after the first few sessions.**

**CONFIDENTIALITY:** The laws of the State of Washington require that most issues discussed with a psychologist remain strictly confidential unless you waive that privilege of confidentiality by signing a “Release of Confidential Information” form.  In addition, these laws require the release of confidential information if: (1) you are physically abusing a child (2) suspected of sexual child abuse, (3) planning to harm someone else, (4) you are HIV positive and you are recklessly behaving in ways that could spread HIV, (5) you are going to commit a felony, or (6) you are a danger to yourself, to others, or are unable to meet your basic needs for survival.  In these cases, I am required by state law to   
inform the appropriate authorities. Courts may subpoena records and judges my issue court orders requiring disclosure of records and information in court.  I may provide you with appointment reminders such as voicemail messages.  If you have been referred by another therapist or physician, I will release feedback information to that referral source unless you ask me not to do so.  In addition, I will release information to your insurance company as required by that company for billing and managed care purposes unless you ask me not to do so.  Please understand that many managed care companies require detailed treatment reports in order to authorize sessions.

**APPOINTMENTS**: Individual appointments are usually 50 minutes.  I typically spend 10 minutes writing notes and reviewing information at the end of our appointment.  In order to maximize the effectiveness of therapy, it is important to be on time as your appointment cannot be extended beyond the scheduled time, since this takes away from other clients’ reserved time.  Your appointment time is held exclusively for you.  **If you are unable to keep your appointment for any reason, please give at least 48 hour advance notice (this excludes weekends and holidays to cancel; otherwise you will be charged a $100.00 no show fee which cannot be billed to your insurance.** Clients are expected to pay their co-pay and deductible in full after each session.  Your insurance will be billed accordingly.   
**RECORDS:** I will keep a record of the health care services I provide you for at least seven years.  You may ask to see and copy that record.  You may ask me to correct that record.  I will not disclose your record to others unless you direct me to do so, or unless there is a legal requirement that compels me to do so.

**FEES:**

$ 200.00   Intake Evaluation                                            
$ 160.00   Individual sessions   
$ 180.00   Couples

Sliding scale: 130-160.00  
$ 160.00   No insurance coverage/cash pay at time service   
$ 100.00   No Show Fee                                              
$ 130.00   Psychological Reports, Clinical summaries, Document preparation per hour  
$ 140.00   Psychological Testing per hour  
$ 300.00  Per hour legal documentation and service, e.g., depositions, court time, etc.      
$   25.00   Surcharge for after-hour emergencies, to include emergency phone       
                consultation.

Fees for reports, letters, review of materials and e-mails, and phone calls may be charged on a pro-rata basis according to time actually required.  Fees for reports or letters and certain types of assessments are usually not covered by insurance carriers.     
  
Unpaid bills will be surcharged at 12% of the unpaid balance on a per annum basis.  Bills for which not payment has been made for sixty (60) days will be considered delinquent and will be instituted for collection.  The fact of your doctor-patient relationship and content of therapy may be released to appropriate persons for billing insurance and collection of overdue accounts.

**NATURE AND LIMITS OF RESPONSIBILITY AND LIABILITY IN MY PRACTICE: Pediatric Psychology Associates is simply a business name and an office-sharing arrangement and is not a provider of any kind of treatment or care.  Each associate of Pediatric Psychology Associates is an independently licensed and independently practicing provider.  This means that, while I have a high opinion of the skills and abilities of my associates, I cannot and do not assume any responsibility for the treatment they provide to their clients and they cannot and do not assume any responsibility for the treatment I provide my clients.  At the end of this form you will be asked to sign indicating that (1) you understand that none of us can assume responsibility for the care provided to a client except to the extent that we have each been involved in the direct provision of care to that client, (2) you agree to hold each of us responsible only for care we have directly provided to you or your child as our client and (3) you are therefore releasing Pediatric Psychology Associates as an entity, and any associate of Pediatric Psychology Associates.   Furthermore, while I maintain provider contracts with a number of insurance and managed care companies, I am not an employee for nor an agent of those companies and I cannot and do not take responsibility for decisions your insurance or managed care company makes even though those decisions may have implications for your care.  Therefore, at the end of this form you will also be asked to sign indicating that, in the event of any dispute with your insurance or managed care company, you agree to hold me, the therapist, harmless and to not take action against me.**

**EMERGENCIES:** In the event of an emergency and I am unable to be reached at my office number (360) 754-4662 or my pager number (360) 481-4429, you are advised to call the Crisis Clinic at (360) 586-2800 or to call or present to the emergency room at St. Peters Hospital (360) 493-7289 or to call 911.   
**GUARANTEES AND PROMISES:** When you request treatment or an evaluation for yourself or for a person for whom you are responsible, be assured that I shall do my best to perform all services in a professionally competent manner and to treat you and your child with dignity and respect.   I cannot guarantee that the results of my evaluation or therapy will conform to your every expectation and I make no promises to determine any particular diagnosis or to reach any particular conclusion from an evaluation.  Effective psychotherapy can at times be confusing and emotionally painful.  Effective treatment and accurate assessment depend to a significant degree on your openness, your commitment to change, and our mutual collaboration.  You may at any point, discontinue services with me, request a change of therapy, or request a referral to another therapist.  My licensure in the State of Washington insures some attention to competence and provides a complaint/discipline recourse and procedure.  You may address concerns which we are unable to resolve to the Examining Board of Psychology, 1300 Quince Street, Olympia, WA 98504-7868 (360) 753-2147.   
   
   
 

**Agreement to Disclosure Statement Terms, Consent to Psychological services**

**and Agreement to Accept Limits Provider Responsibility:**

I acknowledge that I have received copy of the Statement of Office Policy and Privacy practices for the office of Jeffrey R. Petra, Ph.D.  This statement describes the types of uses and disclosures of my protected health information (or that of my child) that might occur in my treatment, payment for services, or in the performance of this office’s health care operations.  It also describes my rights and the responsibilities and duties of this office with respect to my protected health information.  I understand the terms of the evaluation and/or therapy process and agree to participate as it is described and to be responsible for fees incurred unless other arrangement have been made.   
The Statement of Office Policy and Privacy Practices are also posted in this office and copies are available upon request.  The Office of Jeffrey R. Petra, Ph.D. reserves that right to change the privacy practices that are described in this statement.  If office policy or privacy practices change, I will be offered a copy of the revised Statement of Office Policy and Privacy Practices at the time of my first visit after the revisions become effective.   
A photocopy or facsimile of this form and signature(s) will be considered as valid as the original.   
   
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Signature of Patient/Parent/Guardian                                  Date   
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Signature of Psychologist                                                    Date