Patricia Worthey Ph.D. P.S.

Washington State Psychologist License #1812

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(206) 669-4328

Child / Adolescent Outpatient Services Contract

Child or Adolescent Name ______________________________M/F_____ Date__________

Child / Adol. Birth Date:__________Age:_____Adol. Cell Phone #:_____________________

Adol. Email: __________________________Child / Adol. Social Security #_____________

***Primary Parent Name*_________________*Relationship to child* ______________**
(Mother, Father, Step-Parent, Legal Guardian, etc.)

Primary Parent Occupation _________________Place of Employment: _________________

Address____
Street City State Zip Code

Cell Phone (___)______________________ Home Phone (___)______________________

Work Phone (____)____________________ Email _______________________________

Briefly explain your reason for seeking treatment at this time for your child or adolescent:

How were you referred to Dr. Worthey? ____

INSURANCE: You have the right to choose whether or not to utilize your insurance benefits.
I choose to use *my insurance benefits. YES____________NO__________(please initial)*

Please bring your insurance cards with you for me to copy. Please list the information here as well because sometimes the insurance numbers on the insurance cards do not copy well:

PRIMARY **Insurance Co.**	**Subscriber's Name & Date of Birth**	**Insurance ID # (See Ins. Card)**	**Group # (See Ins. Card)**

If you have secondary insurance, please list it here:

SECONDARY **Insurance Co.**	**Subscriber's Name & Date of Birth**	**Insurance ID # (See Ins. Card)**	**Group # (See Ins. Card)**

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Secondary Parent Name**_______________*****Relationship to child*** __________
(Mother, Father, Step-Parent, Legal Guardian, etc.)

Occupation ______________________ Place of Employment: _________________________

Address____
Street City State Zip Code

Cell Phone (___)_____________________ Home Phone (___)________________________

Work Phone (____)___________________ Email ___________________________________

INSURANCE & THIRD-PARTY PAYERS:

Dr. Worthey will bill your insurance plan or third-party payer. You are responsible for obtaining prior authorization for treatment from your insurance carrier or third-party payers. You are also responsible for co-payments and deductibles according to your benefit plan, due at the time of each appointment, and to advise Dr. Worthey of any changes in your insurance or other benefit plans. There is no guarantee your insurance company will pay for the sessions, and you are responsible for your bill whether or not your insurance pays. Some insurance companies may require exceptions to this based on our contract with them. Non-covered services (e.g. extended sessions, travel expenses, telephone calls, etc.) will be your responsibility. You should also be aware that your contract with your health insurance company requires information relevant to the services provided to you and your child or adolescent. In addition to requiring a clinical diagnosis, sometimes your health insurance company will request additional clinical information such as treatment plans or summaries, or copies of your child's or adolescent's entire Clinical Record. In such situations, I will make every effort to release only the minimum information that is necessary for the purpose requested and communicate with you what information is being sent.

Name of Person Responsible for Bill or Insurance: ***(If this is different from the parent:)***

________________________________***Relationship to Client*** _________________________

Address____
Street City State Zip Code

Cell Phone (___)_____________________ Home Phone (___)_______________________

Work phone (___)______________________Date of Birth:____________________________

If I use my insurance, I agree to provide a copy of the primary and/or secondary insurance cards for billing purposes. My signature below authorizes the release of any medical or other information necessary to process this claim. I hereby assign payment of insurance benefits directly to Patricia A. Worthey Ph.D. P.S.

Signature____Date ___________________

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PSYCHOLOGICAL SERVICES PROVIDED

Welcome to your first visit and congratulations on your decision to seek therapy. Raising a child or adolescent is not an easy task. As you know, they do not come with manuals. As a parent, it is sometimes challenging to know exactly how to best help your child or adolescent. Often, just deciding to make an appointment is an important first step. Therapy is not easy; it takes hard work and courage, on both the part of the parent and child or adolescent. I am committed to helping you and your child or adolescent work toward wellness, healthy growth, and change.

I view therapy as a *collaborative experience* between the child or adolescent, the parents, and the therapist with the goal of promoting self-discovery, learning, and healing. The key to successful therapy is providing a safe place where thoughts, feelings, and behaviors can be explored in a compassionate and non-judgmental atmosphere. Our work focuses on helping you and your child or adolescent develop and practice healthier thought and behavior patterns and more adaptive ways of coping. The first 2-3 sessions of your therapy will involve a comprehensive assessment of your child's or adolescent's needs and developing individually tailored treatment goals with you. During this time, we can both decide if I am the best person to provide the services you need in order to meet your child's or adolescent's treatment goals. If we decide to move forward, a proposed course of treatment will be suggested as we progress through therapy. Therapy usually consists of 45-minute sessions weekly or every other week or as needed.

ABOUT DR. PATRICIA WORTHEY

I have been practicing as a psychologist in private practice for the past 20 years. My doctoral clinical internship was specialized in treating children, adolescents, and families at the *Des Moines Child & Adolescent Treatment Center.* I currently treat children, adolescents, adults, couples, and families experiencing a wide range of psychological issues. I work with clients to help maintain hope and determination in the face of what sometimes appear to be overwhelming problems. Areas of practice include anxiety, depression, obsessions and compulsions, panic, social anxiety, attention issues, behavior problems, family conflict, GLBT issues, grief, separation, divorce, trauma, abuse, as well as others. I practice a bio-psycho-social approach to treatment, drawing from current research-based theoretical frameworks which may include, but are not limited to: Cognitive-Behavioral Theory (CBT), Psychodynamic Theory, Exposure Response Prevention Therapy (ERP), Behavioral Therapy, Gottman Marital Therapy, and Emotionally-Focused Therapy (EFT). I received my doctorate in Clinical Psychology from the University of Virginia in 1992, and became professionally licensed in Washington State as a Psychologist in 1994. I am a member of the American Psychological Association and a Certified Gottman Therapist with the Gottman Relationship Institute.

FINANCIAL INFORMATION

This Child / Adolescent Outpatient Services Contract contains important information about my professional services and business policies. When you sign this document, it will also represent a legally binding client-therapist agreement contract. You may revoke this Agreement in writing at any time. That revocation will be binding unless there are obligations imposed by

your health insurer in order to process claims made under your policy, or if you have not satisfied any financial obligations which you have incurred.

FEES: The initial session, or diagnostic interview, charge is $210.00. The Individual therapy charge is $150.00. Family and Couples therapy sessions are $160.00. Insurance or third party payers will be billed at your request. See section below. Fees will be charged and pro-rated hourly for emergency calls and consultations, phone calls, travel expenses, reports and consultations with attorneys, doctors, and other professionals. Psychological testing fees vary according to the time and materials needed.

PAYMENT: Fees for service are due at the time the service is provided. Full payment is expected with your first session, unless your insurance specifies otherwise. Co-payment is required at each session. Please be sure to make all checks and money orders payable to Dr. Patricia Worthey. Checks returned by your bank for non-sufficient funds will result in a $30 NSF check fee. If no payment has been made on accounts over 90 days, the account will be sent out of the office for further collection. This will require that otherwise confidential information be disclosed to the collection agency, such as name and address, billing information, the nature of services provided, and the amount due.

MISSED OR CANCELLED APPOINTMENTS: My office requires 24 hours advance notice on a weekday or 48 hours advance notice on a Monday or weekend to cancel an appointment without charge. My confidential voicemail is available to take your message, seven days a week, twenty-four hours a day. Your account will be charged the full fee for a missed appointment or an appointment cancelled without the required advance notice. Please note that the full charge is your responsibility; insurance carriers will not cover any portion of this charge.

EMERGENCIES

In case of an emergency, don't hesitate to call 911. If you need to speak with me, please call my voicemail at ***(206) 669-4328*** and leave a message. I will attempt to call back within four hours. If you need immediate assistance, or in case I am out of town and I do not call back within four hours, please call 911 or Snohomish County Care Clinic at (***425) 258-4357*** or King County Crisis Line at (***206) 461-3222***. You can also go to the nearest Emergency Room at your local hospital.

LIMITS OF CONFIDENTIALITY

To more fully understand the area of limits on Client Confidentiality, please reference and print out the form located on my website at www.drpatworthey.com - "*Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information*." This is from the Federal HIPAA (Health Insurance Portability and Accountability Act), which sets national standards for protection of confidentiality and electronic transmission of records.

Contents of all therapy sessions, both verbal information and written records, are considered to be confidential. The law protects the privacy of all communications between a patient and a psychologist. In most situations, information about your child or adolescent's treatment can be released to others only if you sign a written *Release of Information* Form. However, there are some extenuating circumstances in which confidential information may be

required to be released, according to state or federal law or as a mandated reporter. Noted exceptions are as follows and outlined in the HIPPA document on my website: Abuse of Children and Vulnerable Adults, Prenatal Exposure to Controlled Substances, Professional Duty to Warn and Protect if a plan has been disclosed to harm oneself or another person, Releasing Minor's Records to Parents, Responding to a subpoena or court proceedings, Worker's Compensation Claims, lawsuits or complaints against a therapist, disclosure to other health care providers, insurance companies and Collections.

PATIENT RIGHTS

Please reference and print out the pamphlet located on my website at www.drpatworthey.com - "*Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information*." Among many patient rights listed in that pamphlet, the following are important:

- You have the right and responsibility to be informed about your treatment; it is appropriate to raise questions about your therapist's training, his/her therapeutic approach and your progress.
- You have a right and responsibility to choose a treatment provider who best suits your needs.
- You have the right to request a change of therapy, referral to another therapist or to discontinue therapy;

The licensing board exists to ensure the public that a psychologist is competent and ethical. Complaints regarding professional and/or ethical issues can be made by contacting the Department of Health, Examining Board of Psychology, PO Box 47869, Olympia, WA 98504-7869, telephone, (360) 236-4910.

INFORMED CONSENT FOR TREATMENT and Agreement of terms

I hereby give my informed consent for psychological treatment services to be provided by Dr. Patricia Worthey to myself, my family, and my child or adolescent. I have carefully read and reviewed copies of both documents listed below and agree to abide by the terms and provisions delineated therein. I give my full informed consent to receive assessment and/or treatment services from Dr. Worthey. A photocopy of this form and signature shall be considered as valid as the original.

□ I have read the HIPPA pamphlet, **"***Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information*", and agree to the terms within.

□ I have read and reviewed this document, "*Child / Adolescent Outpatient Services Contract*" and agree to the terms within.

____
Adolescent Signature (if 13 or older) **Date**

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Parent or Guardian Signature **Relationship to Child/Adol** **Date**

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Parent or Guardian Signature **Relationship to Child/Adol** **Date**

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