Suie Chang, PsyD, PLLC
14201 SE Petrovisky Rd
Suite A3-125
Renton, WA 98058
206-981-6826

INFORMED CONSENT FOR TREATMENT

Purpose of this Agreement
This agreement outlines what you can expect from Suie Chang, PsyD for your psychotherapy services. Client rights and responsibilities, therapist's rights and responsibilities, and business policies are also provided.

Professional Standards and Ethics
As required under Washington law, therapists practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of the public health and safety. It is every client's right to refuse or discontinue treatment at any time. It is the responsibility of clients to choose the provider and treatment modality that best suits their needs and purposes. You may search for individual credentials on the DOH website at www.doh.wa.gov, or call (800) 525-0127.

The Psychotherapy Process
Psychotherapy is a process focused on broadening your understanding of yourself and exploring new ways to deal with the problems or concerns in life. It can also be a process to obtain emotional support while going through a difficult period or under increased stress or life transitions. It may also involve thinking and talking about aspects of yourself that you previously had not been aware of. Particular outcomes are not guaranteed, however I will direct my best efforts to assist you in identifying the nature of any issues that you present and assist or support your efforts to resolving those concerns. Occasionally, information or material discuss may provoke uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, etc. These feelings are not unusual and I encourage you to discuss them with me if they arise.

If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. You are free to discontinue this counseling at any time. Should you decide to work with another clinician I am happy to provide you with referrals, or you may contact the Washington State Psychological Association (206) 363-9772 for names of clinicians in the area.

Therapist Disclosure: Education, Background, Approach
I hold a doctorate degree in Clinical Psychology and am a Licensed Clinical Psychologist (PY60740023) in the State of Washington.

My clients tend to be professional adults in their 20s-40's who are looking to establish effective coping skills for everyday stressors. Common issues addressed include anxiety, ADHD, depression, work-related stress, adjustment disorders, interpersonal problems, and multicultural issues.

I have worked in a variety of settings including children's residential care, community mental health, a university counseling center, and the Washington State Department of Corrections. My experiences have taught me that mental health concerns are universal and present across all demographics.

My approach to therapy involves a collaborative and integrative approach. I view therapy as a process that facilitates individual growth and acceptance. I practice primarily from a Cognitive Behavioral Therapy (CBT) and solution-oriented perspective, but also incorporate Motivational Interviewing, Attachment, Humanistic, Psychodynamic, and Family System interventions.

Confidentiality
All information discussed or obtained during the course of psychotherapy is privileged and confidential. This information may not be disclosed to others without your specific consent or in the event of a minor child, the consent of the legal guardian. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your prior written permission. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time.

The following are legal exceptions to your rights to confidentiality and I am required by law to report any of the following three situations:

1. If I believe you have made a serious and imminent threat of harm to yourself, I can legally inform the police or the county Mental Health professionals with my concerns.
2. If I believe you have made a serious and imminent threat of harm to another person, I am legally obligated to inform local authorities and to inform the intended victim, if I know whom that person is.
3. If I believe that you are physically or sexually abusing a child, an elderly person, or a vulnerable person, or if you report information about the possible abuse of a child or elderly person, I required by law to report the information to Child Protective Services or Adult Protective Services . This law pertains to *current* or *future* behavior and does not pertain to past behavior.

In these instances, I am required to make a report to the appropriate authorities and/or individual(s) threatened. In addition, the courts may subpoena treatment records in certain

circumstances. Every effort will be made to discuss any release of confidential information with you.

Age of Consent
In accordance with RCW 71.34.530: Any minor thirteen years or older may request and receive outpatient mental health treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen.

When Your Child is the Patient
My primary role is as therapist to your daughter/son. Psychotherapy works best when patients can trust their therapist to treat sensitive concerns confidentially. Parents (or guardians) also have a legitimate need to know how psychotherapy with their child is progressing. I will ask you to agree to respect the privacy of your child's treatment records, but will plan to hold regular consultation with parents (or guardians) to keep you posted on your child's progress. I will contact you immediately if I believe that your child's behavior constitutes a risk to herself/himself or others. It is important that we speak about any concerns you may have regarding risky behavior.

Forcing discussion of a child's psychotherapy in court or legal proceedings can undermine the therapeutic relationship and prove harmful to the child. As I begin treating your child in psychotherapy, we all agree that my work will not involve any evaluation relevant to legal matters. By signing this form, you agree that you will not call me as a witness to testify in any child custody matter or other legal proceeding. Should this agreement be broken, my fee is $350/hr for court-related matters, with a minimum of 8hrs.

Record Keeping
The law and standards of my profession require that I maintain confidential records of therapy session. These records may include your diagnosis, a description of your treatment, any professional consultations, attendance/billing records, social/medical/previous treatment history, and any reports that have been released, including reports to your insurance carrier. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. You have the right to a copy of your file. You have the right to request that I correct any errors in your file. I maintain your records in a secure location, in accordance of HIPPA requirements.

Appointments
Individual psychotherapy appointments are generally scheduled on a weekly basis. Psychotherapy is most effective when meeting times are regular and consistent. Each session is scheduled for 53 minutes. If you arrive late, we will only be able to use the remaining appointment time, as your appointment will not be extended beyond the scheduled time. If there is a pattern of missed appointments (ex: 2 cancellations in a row or 2+ within a month),

your reserved appointment time may not be guaranteed for future sessions. Your file will be automatically discharged/closed after 6 weeks without contact/sessions.

Services and Fees

- The initial intake appointment (first session) is $280.
- Individual psychotherapy (50-55 minutes) is $200 per session.

Late Cancellation and Missed Appointment Policy

In order to provide you with optimal care, your appointment time is held exclusively for you. A minimum of **24 hours notice, prior to your scheduled appointment time is required for cancellations. No shows/late cancellations will not allow me to fill the appointment time that has been reserved for you. Late cancellations and missed appointments will be charged the full fee for that session ($200 for therapy appointments).** The **only** exception to this policy is for cancellation in the event of severe weather where you would be endangering yourself by attempting to come (for instance, driving on icy roads).

This outstanding balance must be addressed *prior* to additional psychotherapy services rendered. This can be done by establishing a payment plan or paying the balance in full. Notification for cancelled appointments can be made through phone: 206-981-6826 (voicemails are time stamped) or by email: schangtherapy@gmail.com.

***Please note: Insurance companies do not cover late cancellation or missed appointment fees.**

Financial Responsibility and Billing Practices

A credit card on file is required to reserve your appointment. Payment in full is due at the time of service, including private pay amounts, copays, coinsurance and deductibles. Regardless of insurance or other coverage, the final responsibility for the payment of fees is yours. I accept cash, check, and credit card payments. I can also charge HSA/FSA cards.

Insurance

I currently accept Premera, Kaiser PPO/First Choice, Lyra health plans. I can also bill out-of-network if we are not covered by your plan, and you have out-of-network benefits available. Please provide full insurance information and your insurance card upon your initial visit to determine eligibility of benefits, and obtain authorization from your insurance provider when necessary prior to your first visit. If you have a change in insurance, please let me know as soon as possible, so we can ensure payment.

If your insurance plan requires pre-authorization for services, **it is ultimately the responsibility of the client to obtain this authorization *prior* to being seen by your provider**. If you fail to obtain authorization, any and all charges incurred and not reimbursed, will be your financial responsibility.

Please be aware that your contract with your health insurance company requires that I provide it with 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.

Collections Efforts
If an unpaid visit balance remains after 60 days, your balance will be turned over to a collections partner and you will receive a series of reminders by phone, email, and letters to notify you of unpaid balance. Billing issues happen, please keep me updated and I can work with you.

Complaints
You have a right to have your complaints heard and resolved in a timely manner. If you are unhappy with your therapy, , please inform me directly so I can address your concerns. If you do not feel the complaint has been resolved, you may also contact the Department of Health, Business and Professional Administration, P.O. Box 9012, Olympia, WA 98504-8001, (360) 236-4700.

Phone Calls & E-mails
I am not in my office on a daily basis. Even when I am at my office, I am often seeing clients and not able to receive phone call/ answer e-mails. If you need to contact me between sessions, you can reach me by leaving confidential phone message at (206) 981-6826. I will make every effort to respond within 36 hours except for Saturdays, Sundays and holidays. You will be billed for non-covered services such as care coordination (primary care physicians, psychiatrists, school, etc.), telephone consultation, clinical/legal write-ups, and crisis intervention at a rate of $2.00 per minute in excess of 7 minutes per week. There is no charge for routine telephone calls to regarding scheduling, appointments, or billing.

Please be aware that e-mail messages may not be confidential or private. I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Crisis Coverage
Due to the nature of my practice, I generally do not accept clients who are likely to require intensive psychotherapy or periodic psychiatric hospitalization. I do not have pager or an answering service. In the event of an emergency (you feel suicidal, homicidal, or have a medical emergency) you should:

- Call 911

- Go to the closest emergency room.

- Call the King County Crisis Line at 1-866-4-CRISIS (1-866-437- 4747).

If you feel that these arrangements will not meet your need, I will be happy to provide a referral to another psychotherapist.

Social Media Policy
If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I do not communicate with, or contact, any of my current or former clients through social media platforms (Facebook, LinkedIn, etc.). I believe that any communications with clients online have a high potential to compromise the professional relationship, your confidentiality, and our respective privacy. Please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Dismissal/Termination of care:
It is your right to terminate your relationship with me for any reason. I may terminate our relationship with you in a few specific cases including missing your appointments, failure to make payments, abusing medications prescribed to you, not following up on your therapeutic plan, etc.

Once you have read and understood this agreement, please sign in the space immediately below indicating that you are agreeing to the terms of this agreement and authorizing me to provide psychotherapy, consultation, and/or assessment services for you. If there is any part of this agreement that you do not understand, please discuss it with me prior to signing the consent for treatment.