

**JENNIFER PELTON, PH.D.**

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Child, Adolescent and Adult Psychologist

Voice-mail (206) 282-2802  
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## **DISCLOSURE AND POLICY STATEMENT**

Welcome to my practice. This document (The Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of initial contact. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or, if you have not satisfied any financial obligations you have incurred.

### **Therapeutic Orientation and Psychological Services**

I provide individual and family therapy for children, adolescents, and adults as well as psychological assessment. In conceptualizing an individual's difficulties, I attempt to integrate the influences of heredity and temperament, developmental level, family relationships, cultural context, and other environmental factors on thoughts, feelings, and behaviors. My treatment approach is primarily cognitive-behavioral, but I tailor my approach to the needs of the client and also rely heavily on ACT, DBT and IFS.

Psychotherapy can have many positive effects, such as improved family and peer relationships, relief from distressing symptoms, and better school performance. However, participating in psychotherapy is work. You may experience uncomfortable feelings such as sadness, anxiety, or anger during psychotherapy, and there are no guarantees. To achieve the best possible outcome for work with children and adolescents, it is usually necessary for parents to take an active role so that positive changes may occur. This means that at different times therapy sessions may involve the parents alone, the child or adolescent alone, or the entire family together. I frequently give "homework" assignments so that skills may be practiced outside the office.

For the first 2-4 sessions, I will be conducting an evaluation of your needs and deciding if I have the expertise to be helpful to you, or if referral to a different professional would be more appropriate. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. We can then discuss whether to continue together or pursue other referrals.

### **Education, Training, and Licensure**

My undergraduate education was completed at Pomona College in Claremont, California, where I received a Bachelor of Arts in Psychology. I received my doctorate in clinical psychology, with a

specialization in child/clinical psychology, from the University of Georgia. I completed a child clinical predoctoral internship at the Stanford School of Medicine where I received intensive training in Eating Disorders as well as comprehensive training in general child, adolescent, and family therapy. I then completed a postdoctoral fellowship in child clinical psychology at the University of Washington as director of a research program to prevent adolescent depression and at the Eating Disorders Program at Children's Hospital and Regional Medical Center in Seattle. I also taught a course at the University of Washington on Child Development for the Masters in Social Work Program.

I am licensed as a psychologist in the state of Washington (#3112). Psychology licensure provides that psychologists have passed a national written exam and an oral examination given by the Washington State Examining Board of Psychology. Inquiries about my qualifications and any complaints about my professional services may be directed to:

State of Washington Department of Licensing  
Health Care Licensing, Psychology Section  
PO Box 9649  
Olympia, WA 98504  
(360)-236-4700

### **Rights and Responsibilities of Clients**

It is your responsibility to choose the provider and type of treatment that best suits your needs. You have the right to ask questions concerning the findings of an evaluation, and the right to raise questions about my therapeutic approach and the progress that is being made at any time. You have a right to discontinue therapy at any time and to receive referral to another therapist. If you are age 13 or older, you have the right to refuse evaluation or treatment.

### **Divorced or Separated Parents**

When parents are separated or divorced, it is usually necessary for both parents to consent to evaluation or treatment for their child and to agree regarding payment for these services. Please note that I do not perform custody evaluations and therefore do not make custody or visitation recommendations.

### **Appointments and Cancellations**

Appointments are usually 55 minutes in length, but we may agree to have shorter or longer sessions, depending on the clinical issue. Similarly, clients are typically seen for weekly sessions, but we may decide to schedule sessions every other week or at longer intervals.

Your appointment time is set aside exclusively for you, and I cannot fill that time slot without sufficient notice. If you must cancel an appointment, please make sure that you get in touch with me at least **24 hours in advance** or you will be billed the **full session fee**. *This includes missing a session due to illness.* Likewise, you will be billed the full fee for your session, even if you arrive late. Your insurance cannot be billed for missed sessions, and you will be billed at the full rate for a missed session.

### **Contacting Me/Emergencies**

You may leave a confidential voicemail message for me at (206) 282-2802, 24 hours a day. I check my messages periodically on business days and will return your call within one business day to two business days. **If you need to contact me urgently, call me on my cell phone at (206)-234-5874, but please note that my cell phone is turned off when I am in session. If you cannot wait for me to return your urgent call, call the King County Crisis Line at (206)-461-3222, go to the nearest emergency room, or dial 911.** If I am gone for an extended period of time I will arrange for a colleague to be available for emergencies.

## **Fees and Billing**

### ***Psychotherapy***

The charge for the first appointment is \$230.00, same as hourly rate. With prior agreement, I will schedule a 45 minute session for \$200. I also charge this amount on a pro-rated basis for other professional services, such as school conferences that you have authorized, telephone calls lasting over 15 minutes, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$480.00 per hour for preparation and attendance at any legal proceeding.

Payment is due at each visit unless we agree to other arrangements. In the case of minor children, the parent who brings the child for treatment is responsible for payment. If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collections agencies or small claims courts which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

## **Insurance Reimbursement**

I am contracted with Premera insurance. For clients with Premera, I will bill them directly, then bill you for your copay. For clients without Premera, payment is due at the time of service and I will give you a receipt to submit to your insurance for reimbursement. If you decide to submit claims to insurance for reimbursement, you will need to find out such information as to whether or not you need a referral, number of sessions covered, types of problems covered, types of sessions or evaluations covered, and at what rate your insurance company will reimburse you for my services. I will do everything I can to assist in this process, but **it is your responsibility to keep track of this information so that you receive appropriate reimbursement.**

## **Limits on Confidentiality**

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. 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-client 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 requiring the disclosure. If you are involved in or contemplating litigation, you should consult with your attorney about likely required court disclosures.

With your signature on this Agreement, I may disclose information in the following situations:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. If I consult with a professional who is not involved in your treatment, I make every effort to avoid revealing your identity. These professionals are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

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 for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

1) If I become aware that you may be abusing, exploiting, or neglecting a child under age 18, a developmentally disabled person, or an elderly person, a report must be made to the appropriate authorities (RCW 26.44).

2) If you become a danger to others, I must protect the other person(s) and you by warning the other person(s) at risk and report the danger to the appropriate authorities (RCW 71.05.120).

3) If you become mentally ill and become unable to take care of your basic needs or become a danger to yourself or others and also refuse treatment, I must report your condition to the authorities (RCW 71.05).

4) If you tell me that you are suffering from HIV-related illness and do not have a physician providing for your care, I must report the identities of your IV drug using or sexual partner(s) to the local health care officer (WAC 248-100-072).

If such a situation arises, 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.

### **Consent and Confidentiality For Minors**

Legal guardian(s) of children under age 13 have access to protected health information (e.g., receiving notice, consenting to disclosure, having access to records and the right to amend). However, if therapy is to be effective, the child must feel secure that *specific* confidences will not be revealed to anyone, including guardians. These issues will be discussed with the child and legal guardians at the onset of treatment.

Please note that minors 13 years or older may request and receive outpatient treatment without the consent of the minor's legal guardian (s). Clients between ages 13 and 18 also have the right to decide to whom protected health information will be released, including to that person's legal guardian(s).

However, it is usually in the best interests of a teenager that guardians be provided some information, such as education regarding the teenager's diagnosis and treatment, treatment goals, progress toward these goals, and recommendations for continuing or terminating treatment.

Moreover, the psychologist may act in the best interests of the client in deciding whether to disclose confidential information to the legal guardian (s) without the minor's consent (WAC 246-924-361). The psychologist may disclose to guardians or to another health care provider any behavior that may pose an imminent danger to the health or safety of the minor or any other individual (RCW 70.02.050).

Due to the grey area that is introduced when determining "imminent danger," I may inform parents (or a relevant health care provider) of the minor's current engagement in the following high risk behaviors. Please ask for clarification about these situations listed below as needed. If any of the situations should arise during your treatment, I will remind you about these limitations and make every effort to arrive at an agreement with you, my client, about the best way to inform parents (or other health care provider) of the behavior so that we can keep you safe.

### Nonaccidental self-harm

Nonaccidental self-harm includes behaviors such as cutting, scratching or burning oneself, and abuse or overdose of prescription drugs or other substances.

### Eating Disordered Behavior

Behaviors associated with eating disorders pose a medical risk and I will therefore need to act to protect your safety should you tell me that you are purging (inducing vomiting or using laxatives) or are restricting your eating to the extent that your weight has fallen to below 90% of what is estimated to be your ideal body weight. Excessive exercise may also fall under this category.

### Drugs, Alcohol, and Cigarettes

If you tell me that you are involved in any current use of alcohol, cigarettes, or illicit substances, your parents may need to be informed.

### Other high-risk behaviors

It is impossible to list all possible behaviors that might pose an imminent danger to health or safety. Other examples include unprotected sex, carrying a weapon, failing to take prescribed medications as needed, or any other behavior that may pose an imminent danger to your health or safety.

Confidentiality issues between the teenager and legal guardians will be discussed and clarified at the onset of treatment.

### **Limits on confidentiality for parents of minors**

For minors age 13 to 18, information provided by parents in the context of their minor's evaluation or treatment is considered part of the minor's protected health information (and is therefore documented in the minor's record.)

### **Professional Records**

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you and this is called your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in the unusual circumstance that I conclude disclosure could reasonably be expected to cause danger to the life or safety of the client or any other individual or that disclosure could reasonably be expected to lead to the client's identification of the person who provided information to me in confidence under circumstances where confidentiality is appropriate, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of 65 cents per page for the first 30 pages and 50 cents per page after that, and a \$15 clerical fee. I may withhold your Record until the fees are paid. The exceptions to this policy are contained in the attached Notice Form. 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 Rights Regarding Protected Health Information**

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**Jennifer Pelton, Ph.D.**  
**Licensed Psychologist**

**Notice of Psychologists' Policies and Practices**  
**to Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

– *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

– *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- “*Use*” applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes.

“*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child and Vulnerable Adult Abuse:** If I become aware that you may be abusing, exploiting, or neglecting a child under age 18, a developmentally disabled person, or an elderly person, a report must be made to the appropriate authorities. (RCW 26.44)
- **Danger to Others:** If you become a danger to others, I must protect the other person(s) and you by warning the other person(s) at risk and report the danger to the appropriate authorities. (RCW 71.05)

- **Health Oversight:** If the Washington Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **HIV-related issues:** If you tell me that you are suffering from HIV-related illness and do not have a physician providing for your care, I must report the identities of your IV drug using or sexual partner(s) to the local health care officer. (WAC 248-100-072)

#### IV. Patient's Rights and Psychologist's Duties

##### Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by mail with a revised version of this document.

#### V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact me at my business address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, D.C. 20201 (877-696-6775 toll free).

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM ATTACHED.**

**CLIENTS AGE 13 AND OVER:**

I have read and understand the above policies and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself.

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Date

Client (13 years and older)

**PARENTS:**

I have read and understand the above policies and have had the opportunity to ask questions. I give permission for evaluation and treatment for my child, and state that I am the parent or legal guardian for this child,

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child's printed name

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Date

Parent/Guardian Signature, Printed Name

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Date

Parent/Guardian Signature, Printed Name