

# Christine Clancy, Ph.D., ABPP

Board Certified in Clinical Neuropsychology  
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Welcome to my practice! I am pleased to have the opportunity to work together. This document contains important information about my professional services and business policies. Please read this handout carefully and bring any questions you may have to our next meeting so that we can discuss them.

I work with a group of independent mental health professionals, under the name **The Center for Child Development**. This group is an association of independently practicing professionals which shares certain expenses and administrative functions. While the members share a name and website, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

## **PSYCHOLOGICAL SERVICES**

### **Therapeutic Services**

As a Clinical Psychologist, I provide individual psychotherapy services to children and adolescents. My training has been in a broad range of approaches including life-span developmental, cognitive-behavioral, and family systems. My approach to clients is to individualize treatment programs in order to accommodate optimally the needs of the individuals involved. When working with children, concerns commonly presented to me include behavioral and emotional challenges, poor school achievement, attention problems, learning disabilities, self-esteem, anxiety, medical issues, and adjustment reactions to loss (death, dying, and grief) and divorce.

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the client, as well as the particular problems which the client brings to the session. There are a number of different approaches which can be utilized to address the problems many people bring to therapy. Typically for the most successful outcome the issues will need to be worked on at home as well as in the therapy sessions. In the case of children, parents often need to make changes in their own behavior in order to help their children to change.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, anger, or anxiety. Therapy can often involve talking about unpleasant aspects of a person's history and behavior. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, and better relationships and problem solving, but there are no guarantees.

My normal practice is for the first couple of sessions to have both an evaluative and treatment focus. During this time I will be learning information about your child and, in collaboration with you, I will be outlining a treatment plan. Please feel free to ask questions because you and your child should also be evaluating how comfortable you are with the direction we are taking.

### **Neuropsychological and Psychoeducational Evaluation Services**

In addition to my psychotherapy services, I am Board Certified in Clinical Neuropsychology through the American Board of Professional Psychology. I conduct comprehensive neuropsychological evaluations that assess the thinking skills of children and adolescents aged 3-19 with acquired brain injuries (e.g., encephalitis, meningitis, brain tumors, hypoxic/anoxic injuries), traumatic brain injuries (e.g., non-accidental injuries, concussion, motor vehicle injuries), and congenital, neurological, and medical conditions (e.g., developmental delay, cerebral palsy, epilepsy) taking into account the impact of trauma, chronic and acute illness, and medical conditions on overall functioning. I also conduct giftedness assessments and evaluate children suspected of having learning disabilities, ADHD, and autism spectrum disorder.

### **Consultation Services**

At the request of the client, I provide consultation services to teachers, physicians, other therapists, daycares and treatment facilities. Please note, these services are often not covered by your insurance and thus fall under your responsibility for payment.

### **EDUCATION, TRAINING AND LICENSURE**

I received a doctorate in Clinical Psychology from the University of Toronto, in Toronto, ON, Canada. As part of my doctoral degree, I completed a one year pre-doctoral internship at Holland Bloorview Kids Hospital in Toronto, Canada. Following that, I completed a two year post-doctoral fellowship in pediatric neuropsychology at Nationwide Children's Hospital in Columbus, OH. I currently work in the Division of Rehabilitation Psychology at Seattle Children's Hospital as a Rehabilitation Psychologist and Pediatric Neuropsychologist. My resumé is available for review if you desire.

Psychology licensure provides that psychologists have passed written and oral examinations administered by the Examining Board of Psychology for Washington State and attests that Psychologists are qualified to engage in the independent practice of psychology. The Washington State licensure law provides complaint and discipline recourse procedures for clients. Inquiries about a psychologist's professional qualifications and/or treatment may be directed to the Examining Board of Psychology, Division of Professional Licensing, P.O. Box 9649, Olympia, WA 98504. I have been licensed as a Psychologist in Washington since 2008. My license number is 3878.

### **CLIENT RIGHTS**

Clients 13 years of age and older have a right to refuse treatment. Clients have the right to change therapists or receive a referral to another therapist. Clients have a right to ask questions concerning the findings of their evaluation and treatment, and the right to raise questions about the therapist, the treatment approach, and progress made at any time.

### **CONFIDENTIALITY**

In general, the confidentiality of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with written permission. However there are several exceptions:

Minors - If you are under 18 years of age, please be aware that the law provides your parents with the right to examine your treatment records. It is my policy to request an agreement from your parents that they consent to give up access to your records. If they agree, I will provide them with only general information about how your treatment is proceeding, unless I feel there is high risk that you will seriously harm yourself or others. In that case I will notify them of my concern. Before giving information I will discuss the matter with you and will do the best that I can to resolve any objections that you might have about the information I am about to discuss.

Harm to Self and Others- I am legally required to take action to prevent others from harm, even though that requires revealing some information about a client's treatment. If I suspect a child is being abused, I must file with the appropriate agency. If I believe that a client is threatening serious bodily harm to another, I am required by law to take protective action, which may include notifying the potential victim, notifying the police, or seeking the appropriate hospital treatment. If a client threatens to harm him or herself I may be required to seek hospitalization for the client, or contact family members or others who can provide protection. These situations rarely arise in my practice. Should they occur, I will make every effort to fully discuss it with you before taking action.

Professional Consultation – I may occasionally find it helpful to consult about a case with another professional. In these consultations general information about the case is shared but every effort is made to protect the identity of the client. Additionally, the consultant is legally bound to keep the information confidential. Additionally, medical consultations may be requested as part of your treatment. In this situation, I may formally ask your permission to consult with your primary care physician or that of your child. You are strongly encouraged to inform you primary care physician, or child's physician, that your child is in therapy with me.

## **OFFICE PROCEDURES**

Phone Calls - I am typically in my Bellevue office on Mondays and Fridays from 9:00 a.m. to 7:00 p.m. I am in my Seattle office on Thursdays from 9:00 a.m. to 7:00 p.m. Most of the time I am with clients and unable to receive phone calls; however, phone messages can be left on my confidential voice mail 24 hours of the day (206-999-3576) or you can send me a text message. **I will make every effort to return your call within 48 hours with the exception of Sundays and holidays.** If you have an emergency and feel that you cannot wait until I am able to return your call, please call the Crisis Line at 206-461-3222 or go to your nearest hospital emergency room and ask for the psychologist or psychiatrist on call.

Divorced or Separated Parents - Parents who are going through a separation or divorce often seek therapy for their children to help the child to deal with the stress/loss and adjust to the changes involved. It is my policy, with rare exceptions, that both parents of the child must consent in writing to treatment for their child and to payment before the child is seen. Please be aware that I function as the child's therapist only, and do not perform custody recommendations. In addition, it is essential for the child's privacy to be respected and for their therapy not to be entangled in legal issues. Therefore, you will be asked to sign an agreement to protect your child's confidentiality in court matters. If you do not feel comfortable with this policy, I will be happy to refer you to another therapist.

Appointments – Initial therapy appointments are approximately 55-90 minutes in length depending on the issues to be discussed. Additional appointments are generally 55 minutes in length, although sometimes I schedule 30 minute therapy sessions for check-ins and younger children. Your appointment begins at the stated time, not when you arrive. Once an appointment has been scheduled you will be expected to pay for it in its entirety unless you provide 24 hours notice of cancellation (or unless we both agree that the appointment was unable to be kept due to circumstances beyond your control).

Fees & Payment - Payment is due at the time that services are provided unless special circumstances require an alternate payment schedule. **In case of minor children, the parent who brings in the child for treatment is responsible for payment.**

- 1) Therapy Sessions: My current fee for the first appointment (between 80 and 90 minutes in duration) is \$240.00. This includes time spent in the initial interview, scoring any evaluation measures, review of past records, and phone call contacts with individuals such as teachers and physicians. My hourly fee for therapy is \$180.00 (\$100.00 for half hour appointments.)

In addition to scheduled appointments, it is my practice to charge \$180/hour on a pro-rated basis for other professional services that you may require such as telephone conversations which last longer than 15 minutes, travel time to/from and attendance at meetings or school conferences which you have authorized, and preparation of records or treatment summaries, as requested.

- 2) Evaluations: For the administration, scoring, interpretation of psychological tests and report writing, 504 letters for schools etc., I charge \$180.00 per hour.

Comprehensive neuropsychological evaluations and neuropsychological consultations carry a separate fee schedule and explanation of costs which can be provided upon request.

Cancellations and No-Shows: Cancellation of appointments **must occur 24 hours prior to the scheduled appointment time.** Failure to show up for an appointment without notification or failing to cancel an appointment 24 hours in advance will result in a penalty fee of the full cost based on the length of the session (e.g., \$180 for a 53+ minute therapy session), as missed sessions are not covered by insurance. You are required to provide a valid credit card (number, expiry date, CSC), which will be automatically charged if a session is missed or cancelled less than 24 hours beforehand. A service fee of 4% will be added to your payment for credit card processing.

Court Appearances – In unusual circumstances, you may become involved in court actions such as litigation which may require my participation. You will be expected to pay for the professional time required even if I am compelled to testify by another party. Due to the complexity involved and difficulty of legal involvement, I charge \$500.00 an hour for phone calls pertaining to the case, review of documentation and preparation time, travel to/from, and attendance at legal proceedings.

Legal Documents and Court Appearances – In unusual circumstances, you may become involved in court actions such as litigation which may require my participation. You will be expected to pay for the professional time required even if I am compelled to generate documents and/or to testify by another party. Due to the complexity involved and difficulty of legal involvement, I charge \$500.00 an hour for preparation, travel to/from, and attendance at

legal proceedings, as well as preparation of any documents requested by you or the court. You will be asked to provide a retainer fee up front equivalent to 2 hours of my time (\$1000). Unused fees will promptly be returned to you.

Outstanding Balances: Accounts *must be paid in full within 30 days of the date of the billing invoice*. In circumstances of unusual financial hardship, I may be willing to negotiate an installment plan or contract. Otherwise, a monthly finance charge of 1.0% is charged to unpaid balances after 30 days to cover the cost of bookkeeping until the balance is zero. A zero balance begins another 30 day cycle. To assist you, I have the capability to accept payment by credit card via Square and a secure website. A service fee of 4% will be added to your payment if I key in your card information, while a service fee of 3% will be added to your payment if I swipe the card using the Square device. Payments by check that are returned as NSF (nonsufficient funds) by the bank will be charged an additional 5% service fee.

## **INSURANCE**

I do not maintain any contracts with insurance companies, with the exception of Premera Blue Cross/Lifewise, Regence Blue Shield, First Choice, and Aetna. I am on their panels and with your permission will directly submit claims to them. Due to the concerns about insurance billing, many clients elect to pay for services themselves. If this is the case, we will decide together on a treatment plan and estimate the length of treatment and cost. Co-pays are due the day of the appointment.

If you pay out of pocket for my services, you may still send requests for payment to your insurance carrier, who may then reimburse you for services. Some plans, however, will reimburse at a lower rate because I am not on their panel of providers. If companies require records in order to reimburse, I will release records to you and you may decide if you wish to send them. As mentioned previously, insurance billing will be done by me.

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)**

THIS SECTION 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.

HIPPA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPPA requires that I provide you with a Notice of Privacy Practices for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you these disclosures at the end of this session. A description of the circumstances in which I may disclose information is provided to you. It is important that you understand fully what confidentiality does and does not mean in the therapeutic relationship. I am happy to discuss any of these rights with you.

### **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 [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], 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 Abuse:** If I, in my professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report such condition to the appropriate authorities and government agencies.
- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse, I must immediately make a report to the Department of Social and Health Services.
- **Health Oversight:** The Examining Board of Psychologists has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, 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.

- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment, and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.
- **Worker's Compensation:** If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Department of Labor and Industries.

#### **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 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 post them in my office or provide you with a revised notice either in person or by mail.

**V. Communication**

Based on the new HIPAA Guidelines I am including the following information about the use of cell phones and emails for communication. Please know that I take every precaution to be careful with my cell phone and computer. However, it is important that you know the potential risks involved with confidentiality when using these devices. Mobile Phone Communication. Please note that if we communicate via my mobile phone by voice or text, your phone number will be stored in the phone’s memory for a period of time and therefore if my mobile phone is lost or stolen, it is theoretically possible that your contact information might be accessed. Note that my mobile phone is itself password protected providing one line of defense against such a breach. Email Communication. If you elect to communicate with me by email, please be aware that email is not completely confidential. All emails are retained in the logs of your and/or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be considered part of your treatment record. Please be aware that I regularly access email communications via my password-protected mobile phone. It is theoretically possible that if my mobile phone is lost or stolen and the password is somehow circumvented our email communications could be accessed.

By signing the acknowledgement section below, I am giving consent for communications via:  
 Email  Phone/Text

**ACKNOWLEDGEMENT SIGNATURE**

Your signature below indicates that you have read the intake document and this agreement fully. It also serves as acknowledgement that you have received the HIPPA notice form. Once you have signed this page, your signature denotes that you understand your rights and responsibilities and constitutes your agreement to the terms described in the intake document.

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

I understand that if I (or my parent/legal guardian) wish insurance reimbursement, it is my (our) responsibility to submit and monitor claims, contacting our insurance carrier if delays occur. I give permission for information to be released to my insurance company when additional information is requested for claim processing purposes.

TO BE SIGNED BY PATIENTS AGED 13 YEARS AND ABOVE:

\_\_\_\_\_  
Name Date

TO BE SIGNED BY PARENTS OF MINOR PATIENTS:

\_\_\_\_\_  
Name Date Relationship to client