Patricia K. Barr, Ph.D., Clinical Psychologist
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617-460-2745

Office Policies and Procedures

This statement explains my fees, services, and procedures, as well as your rights as a patient. Your questions are important to me, so please ask for clarification or further information if needed.

CONFIDENTIALITY: The laws of the State of Washington require that most issues discussed with a psychologist remain strictly confidential unless you waive (give up) a specific part of that confidentiality by signing a "Release of Confidential Information" form. In addition, these laws require the release of confidential information if: (1) you are suspected of 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 (5) you are a danger to yourself, to others, or are unable to meet your basic need for survival. In these cases, I am required by state law to inform the appropriate authorities. Courts may also subpoena records and judges may issue court orders requiring disclosure of records and information in court.

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 must release information to your insurance company as required by that company for billing and managed care. In addition, many managed care companies may require detailed treatment reports to authorize sessions.

APPOINTMENTS: Individual appointments are usually 50 minutes. Please be on time as your appointment cannot be extended beyond the scheduled 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 to cancel; otherwise you will be charged a $90 no show fee which cannot be billed to your insurance**. Similarly, if I fail to give you a 48-hour notice because I cannot keep an appointment, your next session will be discounted $90.**

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 in which case I will include that you requested the change and copy the change onto the 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: Patients and their legal guardians are responsible for their accounts and are expected to pay their bill at the time of service whether medical insurance pays for a portion or not. This includes charges for evaluations, printed materials, reports, letters, consultations, and telephone calls. Payment must be made at the time of the session. When appropriate, I will assist in the completion of insurance forms which your insurance carrier may require.

My fees for service are:

$200 for the intake appointment (first session)

$160 for each 50-minute psychotherapy or consultation hour
$80 for each half hour session

A $20 credit will be applied to any session which is paid in full at the time of service and for which insurance is not being billed. Fees for reports, letters, review of materials, and phone calls will be charged based on time required at the current rate for a therapy session and with the same percent credit for immediate payment. 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 no payment has been made for sixty (60) days will be considered delinquent and collection started, including a claim in Small Claims Court. The fact of your doctor-patient relationship and therapy may be released to appropriate persons for billing insurance and collection of overdue accounts.

EMERGENCIES: In the event of an emergency, you are advised to consider the following options (you might want to put these numbers in your phone contacts under 'crisis')

- Call to 911.
- Call the Crisis Clinic at 360.586.2800.
- Call the National Suicide Prevention Lifeline at 800.273.8255.
- Present directly to the emergency room at St. Peter Hospital, Lilly Road, Olympia - call ahead if possible 360.493.7289.

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. Please let me know your concerns about the process so that we can discuss it and take steps to help the situation. 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 provides a complaint/discipline recourse and procedure for significant concerns which we are unable to resolve; the Examining Board of Psychology 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 a copy of the Statement of Office Policy and Practices for the office of Patricia K. Barr, Ph.D., Clinical Psychologist. 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.

If Dr. Barr changes her office policy or privacy practices change, I will be offered a copy of the revised Statement of Office Policy and 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.

_____ _____

Signature of patient/parent/guardian Date

_____ _____

Signature of minor if appropriate Date

Please initial if you agree:

_____ Dr. Barr may provide me with appointment reminders, billing, paperwork or other routine communications by voicemail messages, texts, emails, or letters.