kirsten bailey erickson, licsw
2743 SW California Ave., Suite 301
Seattle, WA 98116

# Outpatient Psychotherapy Services Contract

This document contains important information about my professional services and business policies. Please read it carefully, and jot down any questions you might have so that we can discuss them at our next meeting.

When you sign this document it will represent an agreement between us.

## Credentials

I hold both a Bachelor's Degree in Social Work from Hood College, Frederick, MD and Master's Degree in Social Work from University of Denver, Denver, CO. I hold a LCSW license in Colorado and LICSW license to practice in Washington. My WA license number is: 60141910. My licenses are in good standing.

## Confidentiality

With limited exceptions (listed below) you have the right to the confidentiality of your therapy. I cannot and will not tell anyone what you have told me, or even that you are in without your prior written permission. Under the Health Care Information Act of 1992 I may not legally speak to another health care provider or a member of your family about you without your prior consent. You have the right to share information with whomever you choose. You also have the right to revoke that permission at any tine.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act ( HIPPA ). This law insures the confidentiality of all electronic transmission of information about you. 'Whenever I transmit information about you electronically (for example, faxing information to another healthcare provider); it will be done with special safeguards to insure confidentiality.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my Internet server provider.

Under normal circumstances no one looks at these logs, they are in theory, read by the system administrators of the internet service provider.
The following are some of the legal exceptions to your right to confidentiality. I will inform you of any time when I think I will have to put these into effect.

a. If I have a good reason to believe that you will seriously harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim

b. If I have good reason to believe that you are abusing or neglecting a child, or vulnerable adult, or if you give me information about someone else doing this I must inform Child Protective Services within forty-eight hours and Adult Protective Services immediately.

c. If I believe that you are in imminent danger of harming yourself I may legally break confidentiality and call the police or county crisis team.

d. I may find it helpful to consult other professionals about a case. During a consultation I do not reveal the identity of a client. The consultant is also legally bound to keep information confidential.

e. I am subpoenaed by the secretary of the Washington State Department of Health Services with regard to a regulatory investigation, or by the judicial system regarding a legal action that involves you.

**Professional Fees**

You are required to pay for your session at the time of service. You not your insurance company, will be responsible for payment of all missed appointments and appointments cancelled without 24-hours notice, unless due to a medical emergency.

Individual and couples sessions are 50-minutes in length. My fees are: $165 for the initial diagnostic evaluation, $150.00 per hour for individuals and $165.00 for a couples session. Phone contact lasting longer than 10 minutes is billed at a prorated, hourly rate. I accept cash, checks and credit cards.

As a professional courtesy I will provide to you, on request, a bill that you can submit to your insurance company for reimbursement. I am an out-of-network provider, not a preferred provider. If your insurance company pays a part of your bill, I am required to provide them with a diagnosis. I am happy to discuss with you any concerns you have about this practice.

**Office Hours/Contacting Me**

Office hours are Monday-Thursday from 8-5 pm. I have voice messaging, which I check throughout the day. I will return calls as soon as I am able. Please leave a number even if you think I have it. You may contact me via text message to cancel appointments or let me know you are running late.

Please keep text messages brief.  Text messaging and emailing is not a secure method of communication, and your confidentiality could be compromised.

If you experience an emergency and are unable to contact me, please call the Crisis Clinic at 206-461-3222 or the Alcohol/Drug Helpline at 206-722-3700.

**Records**

If you prefer that I keep no records, you must sign the written request form (below) for your file. I will note only the dates that you attended and fees paid. Exceptions to this policy include: serious suicidal ideation and planning, intent to harm self or others and instances of abuse (see section on confidentiality).

This is to certify that I wish my therapist, Kirsten Bailey Erickson, LICSW to keep only clinical notes that she might need for my care. These records may not be used for any purposes except insurance reimbursement.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signed(Client)_____Date_____

Signed(Client)_____Date_____

Signed(Therapist)_____Date_____