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Welcome to my practice! I want to give you information about me and about my practice. However, the most important thing I want to tell you is that I view our work together as a partnership. We will work together to identify and understand your concerns, develop problem solving strategies and help you make the changes you need to feel more successful whether at home, school or work. I am able to use a variety of therapeutic approaches, as needed, to help you. If we are doing an evaluation together we will identify your strengths as well as your areas of weakness. We will determine ways to use those strengths as well as ways to overcome or compensate for weaknesses. I give tremendous care and thought to the clients I work with and ask that you join me in this journey we will take together.

Psychotherapy involves both risks and benefits. Psychotherapy may bring up uncomfortable feelings like sadness and anger. You may recall unpleasant memories as well. However, psychotherapy has been shown to be very beneficial for those people who engage in it. Psychotherapy has been shown to lead to a significant reduction in feelings of distress, better relationships and problem solving. Typically for most successful outcomes, the issues will need to be worked on at home as well as in therapy sessions. In the case of children, parents often need to make changes in their own behavior in order to help their children change as well.

This document provides important information about my professional services and business policies. Please read it carefully and bring any questions or concerns to our next meeting so that we can discuss them. Once you sign this, it will constitute an agreement between us.

Education, Training and Licensure

I am a licensed clinical psychologist and have been in practice for over twenty five years. I specialize in individual and family therapy with children, adolescents and adults to address a variety of concerns including coping with parent-child relationship problems, anxiety and depression. I take particular care in psychotherapy to focus on identifying and understanding your concerns and on developing problem solving strategies. I also perform a variety of evaluations for children, adolescents and adults, including psychoeducational evaluations of learning and attention problems, neuropsychological evaluations and psychological evaluations.

I received my doctorate in Clinical Psychology from the University of Delaware. I am licensed in Washington (as well as in three other states). Psychology licensure provides

that psychologists have passed written and oral examinations administered by the Examining Board of Psychology for Washington State and are therefore judged competent to engage in the independent practice of Clinical Psychology. The Washington licensure law provides complaint and discipline resource procedures for clients. Inquiries about a psychologist's professional qualifications and/or treatment practices may be directed to the Examining Board of Psychology, Division of Professional Licensing, P.O. Box 9649, Olympia, WA 98504.

Contacts/Appointments

I am in my office Monday through Friday for appointments. We will work together to make appointments as convenient for you as possible. An appointment is a commitment to our work together. I consider our sessions to be very important and ask you to do the same. Please try not to miss sessions if you can possibly help it. When you must cancel, please give me at least 24 hours notice. If you miss an appointment without giving adequate notice I will have to charge you for the time reserved for you/your child. Your insurance will not cover this charge.

You can leave me a confidential message 24 hours a day on my voice message, 425.739.4772. I check my messages regularly and will make every attempt to return calls on the same or next day. However, if you have an emergency you need to call the Crisis Line at 206-461-3222, call 911, or go to the nearest emergency room. You can also contact me by email at msargentphd@gmail.com. Generally, I am able to check and respond to email on a daily basis, Monday through Friday.

Confidentiality

I will treat all of the information that you and/or your child shares with me with respect and care. It is your legal right that our sessions and my records about you/your child be kept private. If it would be helpful to either obtain information from outside sources or share information with outside sources I will obtain your/your child's written consent. However, confidentiality is not protected in the following situations: 1) If an individual shares information that suggests he/she is at risk for or threatens to harm him/herself, I am required to take steps in order to protect that individual. This usually means telling others about the threat. 2) If I believe an individual may be harmful to someone else I am required by law to take protective action. This may include notifying a potential victim, notifying the police, or seeking appropriate hospitalization. 3) If you are under 18 years of age, it is important to be aware that the law provides parents with the right to examine evaluation and 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 only with general information on how treatment is proceeding unless I feel that there is a high risk that you will seriously harm yourself or someone else, in which 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 you may have about what I am about to discuss.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations and your rights concerning your health information (Protected Health Information or PHI). I must follow the privacy practices that are described in this Notice.

With your signature on a proper Authorization form, I may disclose information in the following situations:

- Consultation with other health and mental health professionals
- Individuals assisting me with my billing processes and procedures
- Disclosures required by health insurers
- Court proceedings
- Government Agency requests information for health oversight activities
- Patient-initiated complaint or lawsuit against me (I may disclose relevant information regarding that patient in order to defend myself.)
- Patient-initiated worker's compensation claim and the services I am providing are relevant to the injury for which the claim was made. I must, upon appropriate request, provide a copy of the patient's record to the patient's employer and the Department of Labor and Industries.

If I have reasonable cause to believe a child has suffered abuse or neglect.

If I have reasonable cause to believe that abandonment, abuse, financial exploitation or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency, usually the Department of Social and Health Services. Once such a report is filed, I may be required to provide additional information.

If I reasonably believe there is an imminent danger to the health or safety of the patient or any other individual.

Expanded Clinical Records Rights

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 Record 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

The right to a paper copy of this Agreement and HIPAA policies and procedures.

I am happy to discuss any of these rights with you.

Divorced or Separated Parents

Parents who are going through a separation or divorce often seek therapy for their children, both to help the child who is exhibiting stress or sadness and also to help minimize trauma for the child. It is my policy that both parents of a child must consent in writing to treatment of the child and payment for services before the child's first appointment. Each parent is responsible for payment of 50% of my un-reimbursed fees unless we agree to other arrangements in writing. It is essential that children have the contents of their therapy kept from becoming entangled in the adult's legal issues. Therefore, you will be asked to sign an agreement to protect your child's confidentiality in court matters.

Fees and Payments

My hourly fee for psychotherapy sessions is \$150. In addition to session time I charge this amount on a pro-rated basis for other professional services such as attendance at meetings or school conferences. My hourly fee for evaluations is \$175 for each face-to-face contact, including the feedback session to share results and recommendations. This hourly fee includes the cost of writing a complete report.

I will bill you on a monthly basis for therapy sessions and you will be expected to pay when you receive your bill. In regard to evaluations, I will send you my bill along with the completed report and expect payment upon receipt of the bill. With regard to insurance, I am currently paneled as a preferred provider by several insurance companies. If I am covered by your insurance plan I will extend you the courtesy of submitting my bill to your insurance company. However, you are responsible for paying any portion of my bill not covered by your insurance company. You are also responsible for keeping track of the number of covered sessions.

You will be charged my regular fee for missed appointments and cancellations not made at least 24 hours prior to the scheduled appointment time. This is because if you give me sufficient notice I can often reschedule the time but if you don't I can't make up for the loss of income. In cases of emergencies I am open to negotiating that fee with you. Please note that as I can't bill insurance companies for missed sessions, you bear the responsibility for the entire fee for missed sessions.

Finally, please know that I truly appreciate this opportunity to work with you and look forward to a successful relationship with you.

Meredith M. Sargent, Ph.D.
Clinical Psychologist
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206-920-4105

Acknowledgement Signature

Your signature below indicates that you have read this agreement fully and agree to its terms.

I have read the policies on confidentiality, patients' rights, billing and insurance procedures and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself (or my minor child). I understand that if I (or my parent/legal guardian) wish insurance reimbursement, it is my (our) responsibility to monitor claims and cover unpaid portions of my bill. I give permission for information to be released to my insurance company for the purpose of processing claims when additional information is requested.

To be signed by clients aged 13 years and above:

Signature

Date

Print name

To be signed by parents of minor patients:

Signature

Date

Print Name

Relationship to Patient