Louise Harris, LMHC
Licensed Mental Health Counselor
27023 164th Ave SE, Suite 109 Covington, WA 98042
206-769-4870; Fax: (253) 639-7145, Email: louise@mindsourcecenter.com
MindSource Center Office Manager: 253-639-7146

Office Policy Agreement

Description of Psychotherapy Services	Fee
Psychiatric Diagnostic Interview	$200
Individual psychotherapy, 30 minutes	$85
Individual psychotherapy, 45 minutes	$130
Individual psychotherapy session, 60 minutes	$200
Family Therapy, 50 minutes	$160
Add On Code -90785 Neurodevelopmental visit	$30
Late cancellation/Missed Appointment	$80
Return Check Fee	$40
Correspondence Rate Per Hour	$150

Office Policies and Other Fees

- **APPOINTMENTS AND CANCELLATIONS:** All sessions are arranged by appointment. Please be prompt to best use the time reserved for you, since sessions cannot be extended if you arrive late. To facilitate scheduling, 24-hours' notice is required for cancellations and rescheduling requests. Monday appointments require notification before 3:00 p.m. the preceding Friday. You will be charged the late cancellation or missed cancellation fee for missed appointments without appropriate notification. Please be aware that insurance companies will not reimburse for missed sessions.

- **ATTENDANCE:** My goal is to provide you and/or your family member(s) with the highest quality of care possible. Regular and ongoing session attendance is the most effective and has the greatest therapeutic impact. In the event that two sessions are cancelled or missed in breach of the above appointment and cancellation policies, or a pattern of habitual lateness or cancellation develops, your future appointments with me may be placed on hold for one week as my office manager will attempt to contact you and resolve the attendance problem. In the event you cannot be contacted, or the attendance issues cannot be resolved, your treatment will be considered terminated and you will receive notice, along with referral assistance mailed to the mailing address you have provided.

- **BILLING/PAYMENT:** Deductibles, co-pays and co-insurance amounts are due at the time of service. We accept MasterCard, Visa or Health Savings Account Cards, checks or cash as payment. Psychotherapy fees are listed above. There is a returned check fee of $40.00. Unpaid balances lasting more than 60 days past due will be charged an 18% interest rate (1.5% monthly). Accounts more than 120 days past due will be referred to collections. Any collection legal fees or costs necessary to collect unpaid balance will be your responsibility.

- **CONFIDENTIALITY:** All issues discussed in the course of psychotherapy will remain in the strictest of confidence unless you choose to sign a release of confidential information (e.g., to speak with or send records to your medical doctor, another treatment provider, or a family member). Your insurance company or its agent may have the right to audit your records for the purposes that may include, but not

limited to: accuracy of claims, coverage of services, medical necessity, proper utilization and appropriateness of services, and appropriateness of billing. Information required by your insurance company for the processing of your claim will be provided to my medical billing service. Exceptions to confidentiality, as provided by law, are explained in the Washington State Department of Health brochure and Notice of Privacy Practices that you are being given today. When Federal and State laws differ, the more stringent law supersedes the other.

- **EMAIL & CELL PHONES**: Please understand that confidentiality cannot be guaranteed using any form of electronic communication. All electronically transmitted information may potentially become compromised and is not considered secure, including use of cell phones. I may sometimes use my cell phone for updating appointment arrival times, scheduling, and for other reasons. My office uses email for automated appointment confirmations, if requested. If you have provided us with an email address, please indicate permission for communication with you for the following purposes, by initialing agreement:

  _____permission to receive automated appointment notifications
  _____permission for email contact regarding scheduling and issues of a non-clinical nature
  _____permission for use of phone texting to communicate regarding appointments
  _____permission to be contacted by cell phone

- **DOCUMENTATION REQUESTS:** The differences between the various mental health disciplines can be difficult to navigate, as many individuals are not completely sure how the services a psychotherapist offers differs from the services offered by most psychologists, psychiatrists, and those of other mental health or counseling professionals. If your situation requires a lengthy assessment report, letters to other professionals and recommendations for interventions in environments such as schools, any of these written requests are not a component of the services paid for by the above psychotherapy fees. Insurance/managed care companies do not reimburse, in any way, for letters, reports, or other similar written requests. There will be a charge of $150 per hour for fulfilling these requests.

- **INSURANCE/MANAGED CARE:** If you are utilizing health insurance/managed care to assist with payment for psychotherapy services, the primary insurance company will be billed directly, unless you request otherwise. Due to excessive administrative costs and processing delays, secondary insurance will not be billed directly. In the event you have both primary and secondary coverage and you wish to obtain reimbursement through the secondary coverage, contact the secondary insurance company for assistance with filing claims. If billing/payment documentation is necessary, contact my office manager at (253) 639-7146. It is your responsibility to follow any plan requirement that applies to you, including co-pay amounts, deductibles, pre-authorization, and referral for services. Your deductible, co-pay or co-insurance amount is required at the time of service. If two sessions have been provided without payment received, further visits may be suspended. Please clarify with your insurance company the specific benefits provided, since any unpaid amounts will be your responsibility to pay.

- **SOLE PROPRIETORSHIP:** There are independent professional psychotherapists who sub-lease office space at 27023 164th Ave. S.E., Covington, WA 98042. These sole proprietors do not, in any way, share responsibility for each other's professional practices. Each maintains an explicit, separate, professional responsibility for their professional practice.

- **TELEPHONE MESSAGES:** Messages may be left on confidential voice mail at 206-769-4870. Due to the nature of an outpatient private practice it may not be possible to respond immediately. **If a situation requires an immediate response, call the crisis clinic at (206) 461-3222, call 911, or go to the nearest hospital emergency room.**

EDUCATION, TRAINING AND EXPERIENCE
Washington state law requires all licensed mental health counselors to disclose their training, education, experience, and approach to therapy to prospective clients. Please feel free to discuss this information with me if you have any questions.

EDUCATION: University of Oregon, Bachelor of Science in Elementary Education. Seattle University, Masters in Counseling

LICENSE: State of Washington Licensed Mental Health Counselor #LH00003878
Mental Health Professional, Adult and Child
Washington State Teaching Certificate
JAHCO Approved Privileges

EXPERIENCE:
Child and family services in individual, family or group situations; private practice, 1996-Present
Clinical supervisor and day treatment program manager, 1995-1996
Case manager, group and individual counseling for mentally ill adults, 1993-1995
Counseling for families and children with Kent Youth and Family Services, 1992-1993
Day treatment and group facilitator for older adults, 1991-1992

APPROACH TO THERAPY
My counseling background includes working with people of all ages; children, adolescents, young and older adults. My theoretical orientation to counseling is primarily person centered. We can discuss this and how it applies to your particular situation.

It is very important to me that your needs in therapy are being addressed on an ongoing basis. We will develop a treatment plan together and you are encouraged to ask questions about it at any time. In order to benefit fully, you will be expected to take an active role with appropriate risks in your therapy. You may elect, at any time, to discontinue your care or ask for a referral to another therapist.

STATE LAW DISCLOSURES
The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Washington State Department of Licensing. Your rights are outlined in the accompanying brochure provided by the State of Washington.

YOUR AGREEMENT: I have read and understand all of this information, including my rights as a patient. I agree to all of the above policies and procedures. I hereby authorize _____ (counselor name) to render mental health services to (patient's name): _____.
A copy of this Service Fee and Office Policy Statement and a copy of the Washington State Department of Health brochure have been provided to me. I have received a copy of the federally mandated Notice of Privacy Practices. In the event I or my child is a current client of _____(counselor name), the date of signatures below will serve as the effective date for the revised and updated fee schedule and office policies and other fees.

Client (13 or older): _____ Date: _____/_____/_____

Parent: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Louise Harris, LMHC License# LH 00003878