Margaret H. Anderson, Psy.D.
1210 Dry Hollow Road, #2
The Dalles, OR 97058
541-298-2298

STATEMENT OF OFFICE POLICIES FOR PSYCHOTHERAPY AND EVALUATION OF CHILDREN AND ADOLESCENTS

Welcome to my practice. Please take a few minutes to review my policies and procedures. This information introduces you to my practice and may help answer questions you have. If you have further questions after reading this or individual concerns not covered here, please feel free to ask me about them at any time.

Credentials. I earned a Psy.D. in Clinical Psychology from Pacific University in 2001. From 2001 to 2008, I was employed at Western Psychological and Counseling Services in Vancouver, Washington as a psychologist. I have been in private practice in The Dalles since 2008. During the course of my education and training and in my professional work, I have provided individual, family and group therapy and assessment services to infants, children, adolescents, and adults. These services were provided in a variety of settings including mental health clinics, community mental healthy centers, schools, and correctional facilities. I am a licensed psychologist in Oregon (#1820) and Washington (PY 2800).

Risks and benefits. I use therapy methods that research and my experience have shown to be effective with most but not all clients. Thus, I cannot guarantee positive results. External factors, such as events in the child's life or irregular attendance, can interfere with the child's progress. In addition, therapy can also lead children to show more acting-out behavior for a time as they are dealing with painful feelings. Please feel free at any time to raise your questions or concerns about the treatment I am providing.

Payment of fees. My fee is $135 per 50-minute therapy session and $200 for initial intake appointments. My hourly fee also applies to other services I may provide you such as telephone conversations lasting more than 15 minutes, report or letter writing, attendance at meetings, and records preparation. My fee can be adjusted to match the requirements of your insurance company or payment source. Payment for services is expected at each session. If you are covered by healthy insurance, the copayment or deductible is due at each session and your insurance company will be billed at least monthly. If you use insurance, then I must send the insurance company a psychiatric diagnosis and often other information they require for payment. If you prefer not to disclose this information, a cash agreement can be arranged instead. It is the client's responsibility to notify me of any changes to insurance coverage, eligibility, or personal address change. I contract with a billing service. My billing agent complies with the same laws related to confidentiality as I do. Delinquent accounts may be tuned over to a collection agency if a regular payment schedule has not been maintained. There will be a $21.00 fee applied for any returned checks due to insufficient funds. There is also a records release fee of $40.00 to cover the cost of my time as well as the cost of copying records.

Emergencies. My office number, 541-298-2298, is a cell phone. I do not answer work-related calls outside of office hours. If you are experiencing an urgent mental health matter, you can text me outside of office hours and I will call you back if I am able. However, if you are in need of immediate assistance, call 911 or go to the nearest emergency room or call the county crisis line at 541-296-6307.

Confidentiality. The information you or your child shares with me is considered private and confidential and will not be shared with anyone unless you have given written permission first. It is your choice whether or

not to give permission. As a parent of a client rather than a client yourself, what you tell me will be covered under your child's confidentiality. Because we live in a relatively small community, it is not unlikely that I will see clients in public. If this occurs, it is my policy not to initiate contact. Instead, I leave it up to my clients to decide whether they want to talk to me as an extra protection of their confidentiality.
Confidentiality has exceptions when information may be shared without your permission:

- if I receive first-hand information about harm done to a child or elder or disabled person,
- if you tell me or I come to believe that you or someone else will be harmed,
- if you or your child commits a crime against me,
- if your or someone else's welfare appears in imminent danger,
- if a noncustodial parent requests information,
- if you fail to pay your bill,
- if I am subpoenaed to testify in court.

Please see my Notice of Privacy Practices. This notice explains the Health Information Portability and Accountability Act (HIPAA), a federal law that provides privacy protections with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations.

Attention minors 14-17 years old. Psychologist may provide treatment to adolescents 14 and older without parental consent. Oregon law requires me to have your parent(s) involved before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. I do not have to involve your parents if you have been sexually abused by your parents, or if you are emancipated. By signing this form you:

- authorize me to contact your parent(s) and give them a summary of your treatment by the third session,
- authorize me to use my best judgment about when to inform your parent(s) about important issues related to your treatment,
- authorize me to release your records to your parents(s) if they request this.

Consent for treatment. By signing below, I authorize Margaret H. Anderson, Psy.D. to provide therapy and/or evaluation services to _____.
I understand that I am also assuming ultimate financial responsibility for the cost of the treatment. I also agree that I have had the opportunity to discuss the potential benefits and risks of the therapy to be done by Dr. Anderson. This consent can be revoked at any time in writing. Your signature below also serves as an acknowledgement that you have received the HIPAA notice described above.

Signature of client:_____Date:_____
(clients 14 and older, please sign)

Signature of parent/guardian:_____Date:_____