

**Office Policies/Privacy Practices & Fee Schedule**

Welcome to Sageview Youth Psychology! We trust your appointments here will be informative and helpful. Clearly understanding our role and office policies will insure that we enjoy a good working relationship. Please read the following information carefully because it will help you use our services effectively. Feel free to ask any questions you may have.

# Office Hours & Procedures

We generally see patients from 8:30 A.M. until 5:00 P.M., Monday through Friday. Appointments are typically scheduled on the hour or half-hour, depending on the provider. Appointments vary in length, but appointments for evaluations last about two to three hours; full-day evaluations are common for adolescents and young adults. Therapy appointments are typically scheduled for fifty-five minutes.

Cancellations must be made twenty-four hours in advance to avoid a charge to your account of $90.00. Losses from missed appointments are not readily absorbed and lead to more rapid fee increases. When an illness leads to a visit to your doctor or hospital, or when weather is severe enough to close the public schools in our area, we will not charge for a missed appointment. Unfortunately, we cannot excuse other illnesses or transportation problems.

Please be aware that the provider with whom you are your working may want to meet with you at the beginning and/or end of a session to update on interim progress and any issues that have arisen. In these instances, it is appropriate for your child to be in the waiting room unattended. However, unless you are directed by your provider to bring your children for family therapy sessions, we request that you make prior arrangements so that siblings are not brought to appointments.

There is limited space in the waiting room, our front office staff is conducting business with other families and/or on the telephone, and other providers are in session. We appreciate your understanding of our need to maintain a respectful level of behavior while in the waiting room and that you are responsible for the behavior of your children while engaged in care at our clinic. As such, our staff is not responsible for monitoring or supervising your children.

# Fees & Services

A list of fees for our services accompanies this document. We will not bill your insurance for certain services, as they are not generally reimbursable under insurance guidelines or because we have chosen not to accept insurance reimbursement rates. You are responsible for incurred charges in those situations. Examples of these include but are not limited to the following: telephone consultation, consultation with other professionals, treatment reports or summary letters, and school visits and conferences.

Fees are due at the time of service. Payments can be made with check, cash, or debit/credit card. We will bill insurance companies with whom we contract, but copays and coinsurance amounts must be paid when you check in for your first appointment. Statements showing dates of visits, charges, diagnoses, and payments are provided upon request. Please note that a $50.00 charge is assessed for returned checks (e.g., insufficient funds, stale date, closed account).

Full payment is required at the time of your first appointment if we do not contract with your insurance company. We can provide documentation, including diagnostic and procedure codes, so you can bill your insurance. However, we are not responsible for negotiating settlement of a disputed insurance claim. In cases involving neuropsychological or psychological evaluations, our policy is to release written reports no sooner than at the time of the follow-up interpretive/feedback session. However, you have the right to inspect and copy the record of your services provided by Sageview Youth Psychology.

# Clients Rights

You have the right at any time during our work together to refuse treatment or evaluation. You also have the right to request information about the purpose of the evaluation &/or treatment, and can request a change of therapy or a referral to another professional. Importantly, you have the right to choose the evaluation and treatment procedures that best suit your individual needs. Moreover, it is always appropriate to ask questions about our professional training, therapeutic and evaluation approaches, and your progress with the assessment &/or treatment.

Finally, we do not conduct evaluations for the purpose of, or for use in, determinations of parenting rights, custody decisions, parent fitness, visitation decisions, and/or related issues. Additionally, please note that we cannot give expert advice or testimony to any court regarding these issues.

# Emergencies

Emergency or extra appointments can be made during regular hours. Additionally, office hours can occasionally be extended to accommodate such needs. However, in the event of an emergency after normal business hours, you should follow the crisis plan we have developed, contact the crisis response network in your area (e.g., Tri-Cities: (509) 783-0500), or go to the emergency room of the nearest hospital.

# Confidentiality/Privacy Practices

We will be most helpful to you if we can collaborate with family members and other professionals with whom you are involved. We feel we can best serve you and your family if medical, developmental, school, behavioral, and emotional concerns are understood and addressed simultaneously and systemically. Please know that the privacy of the health information we gather from you during the course of our work together is important to us. Thus, the confidentiality of this work is upheld at all times, and we will only discuss your case with your primary care physician or other referring professional, if they are involved, and those individuals for whom we have a signed release of information.

On a related note, our respect for your privacy extends into the public setting. Thus, we will neither initiate contact with you outside the clinic nor discuss with you in that setting concerns about your child or his/her progress with treatment. Additionally, as we cannot guarantee the confidentiality of electronic information, we request that you not use email as a means of contacting us.

The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996 and effective April 14, 2003, requires that we take additional steps to keep you informed about how we may use information gathered from you while providing health care services. The following describes how we may use your protected health care information (PHI) to carry out treatment, payment or health care operations, as well as detailing your rights regarding health information we maintain about you and how you may exercise these rights:

1. **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**
   1. **Permissible Uses and Disclosures Without Your Written Authorization**

We may use and disclose PHI without your written authorization, excluding psychotherapy notes, for certain purposes as described below. The examples provided in each category are not meant to be an exhaustive list, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

* + 1. **Treatment.** We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI to diagnose and provide neuropsychological and/or psychological services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.
    2. **Payment.** We may use or disclose PHI to appropriately bill to and receive payment from your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. Similarly, we will release your name, identifying information, how to reach you, and amount owed if it becomes necessary to contact an attorney or collection agency about an unpaid bill.
    3. **Health Care Operations.** We may use and disclose PHI in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.
    4. **Required or Permitted by Law.** We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others, including your child. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosure to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful processes; disclosures for research when approved by a institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.
    5. **Records of Disclosure.** Records of disclosure of PHI without authorization will be maintained in the case record as required by HIPAA standards. Records of disclosure will include:
       - A description of the information to be disclosed
       - Who (individual or organization) is making the request
       - Expiration date of the request
       - A statement that the individual has the right to revoke the request
       - A statement that information may be subject to re-disclosure by the receiving party
       - Signature of the client or their representative and date
       - If signed by a representative, a description of their authority to make the disclosure.

Records of disclosure will be maintained for at least six years from the date of disclosure and in accordance with Washington State Law.

* 1. **Uses and Disclosures Requiring Your Written Authorization**
     1. **Psychotherapy Notes.** Notes recorded documenting the contents of a counseling session with you (“psychotherapy notes”) will be used only by your clinician and will not otherwise be used or disclosed without your written authorization and only as per state or federal law. Psychological work ethics pertaining to this sensitive information will be applied in relation to psychotherapy notes.
     2. **Marketing Communications.** We will not use your health information for marketing communications without your written authorization.
     3. **Other Uses and Disclosures.** Uses and disclosures other than those described in Section I.A. will only be made with your written authorization. For example, you will need to sign an authorization form before we can send your PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.
     4. **Photography.** Photographs, video, digital or other images may be recorded to document care. The clinic maintains these photographs, video, digital or other images as part of your health record. These images will be stored in a secure manner that will protect a client’s privacy. Release of such images outside of the clinic requires written authorization from you or your legal representative.

1. **YOUR INDIVIDUAL RIGHTS**
   1. **Right to Inspect and Copy.** You may request to access your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge for a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor’s medical record will not be accessible to you. Youth who are 13 years of age and older must provide written consent for the records to be released to their parent/s or legal guardian.
   2. **Right to Alternative Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
   3. **Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to me. We are not required to agree to any such restrictions you may request.
   4. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
   5. **Right to Request Amendment:** You have the right to request that we amend your health information. Your request must be in writing and explain why the information should be amended. We may deny your request under certain circumstances.
   6. **Right to Obtain Notice.** You have the right to obtain a paper copy of this notice. In fact, upon reading of this notice and acknowledgement of what is contained herein, you will be allowed to take this copy home with you. If at any time an additional copy is desired, we will happily accommodate.
   7. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the Privacy Officer, Scott D. Grewe, Ph.D., at (509) 627-2600. You may also file written complaints with the Director of the Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.
2. **BUSINESS ASSOCIATES**
   1. **Business Associate Contract.** It is our policy to obtain a Business Associate Contract with any individual or organization who has access to PHI in our possession and who is not a covered entity under HIPPA or a member of our workforce.
   2. **Contents of the Contract.** All Business Associate Contracts will include language that reasonably assures that the Business Associate will appropriately safeguard and limit their use and disclosure of PHI that we disclose to them. In the event that we learn of a breach of the Business Associate Contract by the Business Associate, we will immediately take reasonable steps to correct the problem, including termination of the contract with the Business Associate and reporting to the Secretary of the Department of Health and Human Services.
3. **EFFECTIVE DATE AND CHANGES TO THIS NOTICE**
   1. **Effective Date.** The aforementioned privacy policies and practices are effective April 14, 2003.
   2. **Changes to this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office. You may also obtain any revised notice by contacting us.

**Training & Background**

***Scott D. Grewe, Ph.D., ABPP/CN***

Dr. Grewe received a B.A. in Psychology from Winona State University in 1988 and an M.A. in School Psychology from Ball State University in 1989. He received a Ph.D. in School Psychology, with specialization in Neuropsychology and Counseling Psychology, from Ball State University in 1993. He completed a Predoctoral Internship in Pediatric Psychology at the duPont Children’s Hospital and a two-year Postdoctoral Fellowship in Pediatric Neuropsychology at Children’s Hospital and The Ohio State University, during which time he became a licensed Psychologist in Ohio. He was then a Pediatric Neuropsychologist and Director of the A.P.A. approved Predoctoral Internship at Children’s Hospital until moving to the Tri-Cities in October 1998.

Dr. Grewe currently provides care for children, adolescents, young adults, and their families through Sageview Youth Psychology. He has particular clinical interests in sports-related concussion and the return-to-play process, acquired neurological disorders and their cognitive and behavioral sequelae, and independent educational evaluations to assist parents and school personnel in collaboratively facilitating educational outcomes for their students.

Dr. Grewe has been a licensed Psychologist in Washington since 1999 and obtained board certification in Clinical Neuropsychology through the American Board of Professional Psychology (ABPP) in May 2004. Finally, Dr. Grewe is an adjunct professor at Washington State University Tri-Cities in the Department of Psychology, and Clinical Director for the Children’s Developmental Center. His clinical services are provided in the context of developmental and family systems orientations, although his therapeutic interventions are associated with behavioral and cognitive-behavioral approaches.

***Joan Arrasmith, M.Ed.***

Joan received her B.A. in Psychology from Eastern Washington University in 1991, and began her career promoting independent living for individuals with disabilities. After taking time off to raise her family, Joan earned her M.Ed. in Counseling Psychology from Washington State University in 2009. Her post-graduate experience has included individual counseling for transitioning college students and adolescents, behavior management training for families and children, and counseling and social skills building for young adults with ASD.  Joan recently completed work as a therapist for Seattle Children’s Hospital, where she provided behavior management training for families involved in the Children’s ADHD Telemental Treatment Study (CATTS). Joan is also a co-developer and co-facilitator of a Career Readiness Class for adults with High Functioning Autism at The Responding to Autism Center in Kennewick.

At Sageview Youth Psychology, Joan provides behavior management for children and families as well as individual and family counseling for children, adolescents, and young adults. Her services are provided in the context of developmental and family systems orientations with interventions primarily associated with cognitive-behavioral and behavioral approaches. Joan is a Licensed Mental Health Counselor in the State of Washington and is a National Certified Counselor.

***Michael Whitehead, Ph.D., LMFT***

Dr. Whitehead received his B.S. in Marriage, Family, and Human Development from Brigham Young University in 2007, his M.S. in Marriage and Family Therapy from Brigham Young University in 2009, and his Ph.D. in Human Development and Family Studies from Michigan State University in 2016. The combination of studying child development and training in Marriage and Family Therapy help give Dr. Whitehead a unique view of the family, and how problems develop and are treated. He primarily works with the whole family to find solutions to problems that are manifesting in one or more of the family members. In addition to helping families resolve their concerns, Michael enjoys teaching classes on topics ranging from: couple communication, emotion coaching, child-directed play, parent empowerment, and strengthening marriages.

Michael is also a Registered Play Therapist Supervisor. His inclusion of play therapy as one intervention to use with his clients has increased the success he has had in treating a number of presenting concerns. His primary focus is on families with children and parents who have a diagnosis of ADHD. He has also developed a research based divorce adjustment program for children ages 9-12. He is currently an AAMFT Approved Supervisor, and has supervised a number beginning Marriage and Family Therapists.

***Brooke Flodin, M.S., LMHC***

Brooke received both her Bachelor of Science (2010) in Psychology and Master of Science (2013) in Clinical Psychology from Eastern Washington University. She interned at Partners with Families and Children in Spokane where she worked with children and adults providing individual and family therapy to families who had experienced child abuse and/or neglect as well as facilitated a trauma and recovery group for co-occurring adults. Her post graduate experience includes work with children and families, as well as specialized training in Applied Behavior Analysis (ABA) therapy. She recently completed her work at The Child Enrichment Center where she worked with young children with Autism Spectrum Disorder providing parent education, intensive individual behavioral intervention, as well as assisting with social skills training groups to help increase age appropriate communication.

At Sageview Youth Psychology, Brooke provides individual and family counseling for children, adolescents and early adults. Her services largely involve cognitive-behavioral and behavioral approaches but also include individualizing services to best aid individual and family growth. Her particular interests include behavioral intervention as well as complex traumatic stress. Brooke is a Licensed Mental Health Counselor in the state of Washington.

**Sageview Youth Psychology**

**Fee Schedule (per hour) – Effective January 1, 2017**

## **Initial Consultation: $ 275.00**

### Neuropsychological Evaluation: $ 210.00

Billable time includes interview, administration and scoring of tests,

and preparation of formal report.

### Psychological Evaluation: $ 210.00

Billable time includes interview, administration and scoring of tests,

and preparation of formal report.

### Evaluation Feedback Session: $ 210.00

**Therapy Session:** Intake 45-50 minutes **$ 275.00**

Individual/Family 45-50 minutes **$ 180.00**

**Group Psychotherapy:** 75-90 minutes **$ 125.00**

### \*Consultation Services: $ 190.00

Including phone conversations, letters to schools, physicians, or other

service providers, and treatment summary reports

### \*Consultation with other Professional: $ 190.00

Including meeting with medical and school personnel,

other service providers

### \*School Visit/Consultation: $ 190.00

**\*Insufficient Funds/Returned check fee $50.00**

**\*No Show, Late cancellation fee $90.00**

**\* These services are not billed to insurance**

**Payment is required at the time of service**. You may pay by cash, check, or credit card (Visa, Master Card, Discover, & American Express). Estimated amounts of **$260 or less** require full payment at the time of initial service. Amounts between **$260-500** require a minimum payment of **50%** of the balance at the time of initial service, and payment of the remaining balance the following month. Estimated amounts greater than **$500** require a minimum payment of **25%** of the balance at the time of initial service, and at least equal monthly payments the following three months. Payments are due the **15th** of each month. We require a credit card to be kept on file for families utilizing payment plans and total outstanding charges are processed to that card if monthly payments are not made.

Clients who are fee-for-service, or are covered by an insurance company with whom we do not contract, will be requires to keep a credit or debit card on file. If services are not paid at the time of the appointment, the incurred balance will be charged on the 15th of the following month.

**Office Policies/Privacy Practice Acknowledgement & Payment Responsibility**

I have received and reviewed a copy of the *Office Policies/Privacy Practices & Fee Schedule*. I understand the information contained in this form and consent for my child to receive services at Sageview Youth Psychology. I acknowledge that I am responsible for payment of the services rendered by Sageview Youth Psychology and will comply with the payment policy and fee schedule as outlined in this form. I authorize Sageview Youth Psychology or any collection agencies used by the professionals in this office to contact me by my cellular telephone for billing activities or payment arrangements.

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Client Name (please print) Date

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Parent or Guardian Signature Relationship to patient

**Client Consent** (If the client is 13 years of age or older)

I have received and reviewed a copy of the *Office Policies/Privacy Practices & Fee Schedule*. I understand the information contained in this form and consent to participate in services at Sageview Youth Psychology. I also give consent for Sageview Youth Psychology to communicate with my parents or legal guardians regarding financial and procedural (e.g., scheduling) information.

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Client Name (please print) Date

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Client Signature

\*\*\*Please return this page to the office with your packet.