

*Disclosure Statement and Conditions of Treatment with  
David C. Wade, Psy.D., PC  
Licensed Psychologist # 1081*

**Welcome to my practice. 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. When you sign this document, it will represent an agreement between us.**

**PSYCHOLOGICAL SERVICES:** The experience of psychotherapy varies depending on the personalities of the psychologist, the client, and the particular problems you bring forward. There are a variety of methods I may use to deal with the problems that you hope to address. Together we will determine the course of therapy. Psychotherapy calls for active participation on your part. In order for the therapy to be most successful, at times, you may have things to work on during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. However, psychotherapy has also been shown to have benefits such as new learning resulting in development and changes in neuropathways. Therapy often leads to a better understanding of relationships, solutions to specific problems, and significant reductions in feelings of distress. This journey is unique to you, and it is important to me that you feel empowered through this process.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work might include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If we are not a "good fit," I will provide the names of other mental health professionals for a second opinion or referral.

Therapy is a process of communication and continuity of care. It is your responsibility to set up an appointment. If I have not heard from you within 60 days, your case will be terminated at that time. If you wish to seek follow-up treatment with me, you may contact me, and we can assess my availability, and I can provide other possible resources.

**Examples of Disclosures for Treatment, Payment, and Health Operations:** *I will use your health information for treatment.* I make handwritten and/or computer notes of my initial assessment and all subsequent visits. I may have staff involved in typing, proofing documents, and chart management. Issues of confidentiality and HIPAA also apply to my employees. Records cannot be released without consent unless conditions exceed your rights to confidentiality and privilege. (See section on confidentiality.)

*Your health information may be used for payment. For example, A bill may be sent to you or a third-party payer. Typically, I used electronic billing. That information will also be in the possession of my billing service, KW Billing. Kellie Wade does the billing. She can be reached through me or [kwbill@outlook.com](mailto:kwbill@outlook.com). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, and a procedure code indicating either “mental health assessment” or “psychotherapy.”*

**Treatment Plans:** *Insurance typically requires a patient diagnosis for payment of service. Some insurance plans require the completion of treatment plans, diagnosis, problem list, and plan of treatment. Unless otherwise instructed by you, I will complete treatment plans when due and respond to case reviews in order to authorize payment and continued authorization for your care through your insurance plan. At times insurance companies will require progress notes or the chart. If I receive this request, I will notify you. Once it has been sent, I have no control over what your insurance company does with the information I send them. You may contact your insurance company to inquire about how they manage their records.*

**Confidentiality:** Communication between the client (person or persons identified as receiving treatment services) and the psychologist is privileged. The federal HIPAA laws also protect this information. This means what is shared between the psychologist and client is confidential, and subsequent records regarding patients are confidential, with the following possible exceptions:

1. Abuse of a child or elder. Abuse can be sexual, physical, or emotional involving a child (someone under the age of 18, or in some cases between children who are three or more years apart in age), or someone 65 or older may be reported to the authorities and intended victim(s).
2. A serious threat to harm oneself or another, or crime/behavior that is likely to result in serious danger, may be reported to the authorities and intended victim(s).
3. Public health: As required by law, I may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. clients who are HIV positive and are involved in unprotected sex or sharing of needles will be reported to the County Health Officer.
4. In the event of a client’s death, the records may be released to the beneficiary.
5. A court order. A psychologist can be subpoenaed and required to appear in court with medical records. He/she may share records and talk about a case if a release is signed by the client (or legal guardian in some cases). If there is not a written, valid release, the psychologist may claim privilege, at which time the judge will determine whether to honor the privileged communication or instruct the psychologist to release the records and require the psychologist to testify.
6. To a primary care practitioner or other medical provider if the patient’s health is threatened or in case of a medical emergency. It should be noted that HIPAA laws do not require consent by the client for medical providers to share information. However, unless it is an emergency situation, it is my policy to obtain your consent.
7. If a complaint is filed with the Oregon Board of Psychologist Examiners or legal action regarding services.
8. In the state of Oregon, non-custodial parents may have the right to their child’s treatment records.

9. When working with a child whose parents are divorced. Anything one parent shares with me may be shared with the other parent when I believe this information is clinically appropriate to share. Often there is information I do not believe is helpful to share. My goal is to be an advocate for your child rather than one parent or the other.

10. As part of your contract with your health insurance, and if I am in network, your insurance company may request all your records for review of treatment.

In the above situations, sharing of unauthorized information by the psychologist with the appropriate agency does not constitute a violation of confidentiality. The main avenue for releasing information is by the patient or legal guardian signing a release which allows the psychologist to communicate with others.

Parents of a child under 14 years of age are entitled to any information the psychologist may gain with the said child. However, I request parents agree for me not to share information with them without the youth's authorization. This allows treatment to be more open. I also stipulate if I believe a child is in imminent danger, I will share this information. This will be discussed in the first meeting. Note: when working with a child whose parents are divorced, my role is to advocate for your child. I will not keep secrets between parents. This is to avoid me being caught between parents with opposing agendas. My role is to operate as a therapist, not to evaluate custody.

**Family Therapy:** In the case of family therapy, there may be one family member identified as the primary client.

1. There will only be one chart. I will not release the records unless each member gives me permission. Those under the age of 14 may have their legal guardian make the decision. 2. Each participant 14 years and older will sign the consent to treatment form. This will give me permission to work with them, and also agree that I may speak with all parties involved in the family therapy, freely sharing any information with family members.

3. The limits of confidentiality still apply. **Please Note:** non-custodial parents may have rights to the treatment record. The records have information from all parties, consequently, a non-custodial parent may have access to the records that contain information about and presented by all parties in the family therapy session. If you are a divorced parent in family therapy with a minor child, the child's other parent, even if not involved in the therapy (custodial or not), may have access to all information in the records about the family therapy and members in the family therapy.

**As part of my practice to improve the quality of care.** I have mental health colleagues with whom I consult on a regular basis. Should I discuss your case, identifying information is not shared, and this process allows me to gain different perspectives regarding treatment approaches that might be helpful in our work. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

**Sessions are typically 45 minutes.** This allows me time to return phone calls, make notes, etc., between sessions. Your appointment is time especially set aside for you. 24-hour notice of

cancellation allows me the opportunity to offer that time to another patient. Late cancellation or no-show will result in a \$50 charge for the first two times and the full amount for subsequent occurrences. If you are ill and cancel the day of the appointment, you will not be charged for late cancellation. If we are meeting during the winter months and you don't feel safe driving on the snow and ice, you will not be charged if you call the same day before your appointment.

**Fee Schedule:**

- **The first session** is called an intake and is billed at \$230.
- **Individual therapy** sessions are (\$150 for 45 minutes and \$175 for 55-60 minutes)
- **Family therapy** is \$175 (50 minutes).
- **Consultation and/or participation in meetings** will be billed at the regular session rate of \$150 for 45-50 minutes.

**For shorter meetings**, you will be billed \$100 for 16-37 minutes.

If you have questions, please ask me or contact Kellie at [kwbill@outlook.com](mailto:kwbill@outlook.com). My office uses electronic billing. If you do not want my office to bill you, please let me know.

**Responsible Party:** For outstanding balances, I send the monthly billing statement to one household or one responsible party only. If two or more people from different households share financial responsibility for a patient's medical expenses, I will bill only one of them, the one who signed the intake forms accepting financial responsibility. If someone other than that person wishes to be the responsible party, he or she can fill out and sign intake forms, after which responsibility for the account can be transferred. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection, and you will be held responsible for any legal or collection costs incurred. If, for any reason, such as a health saving account, I will send statements upon request.

**Insurance:** Typically, I will bill your primary insurance company monthly as a courtesy to you and will follow up with them to assist in getting reimbursement for services. If you have secondary insurance, you are required to pay the balance, and I can provide billing you can send to the secondary insurance requesting reimbursement. However, you are responsible to check with your insurance company regarding your coverage and to track this coverage as treatment progresses.

Some things to keep in mind are:

- Are you currently covered?
- Am I a provider whose services are paid under this plan?
- What is your annual deductible?
- What is the percentage of coverage?
- What is the company's "usual and customary rate?"
- What is the maximum benefit for outpatient mental health coverage?

**Remember: You are responsible for the entire bill whether the insurance pays or not.**

**Contacting Me /Crisis Coverage:** If you're experiencing a medical emergency, call 911 or proceed to your nearest emergency room. Suicide prevention hotline: 800.273-8255. You may also call 988, the 24-hour crisis line.

You may attempt to contact me for support on my cell phone at 541-490-9536. **In cases of crisis, DO NOT email or text.** If I am away from my phone for an extended period, this will be on my message if you call my cell phone. If you are unable to reach me and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call or call 911 or 988. If I am unavailable for longer than 24 hours, this will be on my cell phone message. Crisis calls will be charged **\$50.00 for each 15-minute block of time.** Insurance companies typically will not pay for crisis calls. The goal is for our work to be contained during our sessions.

**Legal Proceedings:** If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, even if I am called to testify by another party. My legal hourly fee is \$300. Professional time includes the entire court process, including but not limited to consultation with attorneys, travel time, waiting to testify, and preparing written briefs and actual testimony. Clients entering treatment are agreeing to not involve me in adversarial legal/court proceedings or attempt to obtain records of treatment for legal/court proceedings when marital or family therapy has been unsuccessful at resolving disputes. This prevents misuse of your treatment for legal objectives.

**Patient Records** The laws and standards of my profession require that I keep treatment records for 7 years according to Oregon law. You are entitled to receive a copy of the records unless:

1. I believe that seeing the records would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice.
2. If a request comes after records have been destroyed.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent preparing information requests.

**HIPAA Notice of Policies and Practices** I am required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a Notice that describes (1) how clinical information about you may be used and disclosed and (2) how you can get access to this information. (see HIPAA form)

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. Should my information practices change, it will be posted prominently in my waiting room.

**Contract with David C Wade, Psy.D.**

\_\_\_\_\_ I have read and/or had explained to my satisfaction the information in this contract and give consent for treatment for myself and/or family members under these conditions.

\_\_\_\_\_ I understand the rights and limitations of confidential information.

\_\_\_\_\_ I understand Dr. Wade provides therapy and consultation services. I am entering this agreement for therapy, not legal proceedings or to ask for legal testimony.

\_\_\_\_\_ If using insurance for payment of services, I hereby give permission for the office of David C. Wade, Psy.D., PC Inc. to furnish information to my insurance companies concerning me, my child's or family's psychological treatment. This may include but is not limited to, diagnosis, treatment plan, treatment progress, and notes.

\_\_\_\_\_ I understand it is my responsibility to cancel appointments 24 hours in advance, and there will be an automatic charge of \$50 for the first two late cancellations or missed appointments and a full fee for subsequent missed or late cancellations. Insurance companies will not pay for missed appointments.

\_\_\_\_\_ I also understand and take full responsibility for all payments for services. If using insurance and it does not pay what I expected, it is my responsibility to pay for the delivered services. Delinquent accounts may be turned over to a collection agency.

\_\_\_\_\_ HIPAA information has been reviewed, and I have received a copy. I understand a copy of the HIPAA policy is available in the waiting room.

\_\_\_\_\_ I understand it is my right to ask questions and make comments regarding treatment, appointments, billing, or other issues.

\_\_\_\_\_ I understand, unless pre-arranged, if I have not contacted Dr. Wade in 60 days, my (or my child's) case will be closed.

Signature patient or legal guardian Date

Signature patient or legal guardian Date

\_\_\_\_\_  
Print Name of Patient(s)

David C. Wade, Psy. D., PC Date