THERAPY SERVICES with Dennis Dyck, Ph.D
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Agreement

Welcome to my practice. This document, the **Agreement**, contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices, or **Notice.** The Notice, a separate document, explains HIPAA and it's application to your personal health information in greater detail. Please read it carefully and note any questions you might have so we can discuss them.

Dennis Dyck is an independent practitioner in clinical psychology. He is an experienced psychologist who brings a unique perspective to his practice, allowing him to respond effectively to diverse needs and concerns.

Dennis Dyck has a PhD in Psychology from the University of Oklahoma and completed an APA Approved Clinical Psychology internship at the University of Manitoba School of Medicine. He has been licensed to practice as a Psychologist in the state of Washington (PY00001566) since 1992. Dr. Dyck specializes in adult individual, couple and family relationship issues and health psychology. He utilizes evidence-based treatment approaches, including but not limited to, Cognitive Behavioral Therapy, Dialectical Behavior Therapy and Multiple Family Group Therapy.

For more information about our providers, please visit my web page ddtherapy.com.

Professional Relationships: I have an office sharing arrangement with Dr. Carol Moore, Clinical Psychologist. Dr. Moore's practice is totally independent of my practice; neither practice is responsible for the behavior of the other.

Therapeutic Approach: My therapeutic approach recognizes that each person is an individual with biological, psycho-social, and spiritual aspects of their being. I work to help my clients grow and to lead fulfilled lives no matter what their age, health condition or unique circumstances. I help people to become more aware of their strengths. I also think it is important for us to be aware of our unique challenges so that we can have the wisdom and courage to deal with them and to make good life decisions. Our choices in life transitions are rarely easy, particularly when they involve human relationships. I believe we are designed to live relationally. Because of this, personal growth and self-acceptance are often closely related to the quality of our social relationships. As a therapist I find it fulfilling to help people move toward a more full and productive life. I believe this is most likely to happen when body, mind and spirit are aligned. When they are misaligned, we are fragmented. My goal is to help people become more integrated and aware human beings. I use a variety of strategies to help people but central to the way I work is to provide a safe environment and supportive atmosphere for guided self-exploration and change. I will discuss therapy goals and the proposed course of therapy with you periodically throughout therapy. If you have any concerns or questions, please bring them to my attention. You have the

right at any time to refuse therapy, change therapists, or request a change in therapeutic approach.

Fees: Therapy sessions generally are 40 to 45 minutes ("clinical hour") in length. Fees vary based on the service and the provider. Dr. Dyck's fees are $250.00 for the initial visit and $175.00 for subsequent sessions. The fee for a brief session (20 to 25 minutes) is $100.00; the fee for an extended session (50 to 60 minutes) is $210.00.
Crisis sessions are $5.00 per minute for Dr. Dyck. There is a 5% discount for individuals not using their insurance who pay at the time of service by cash or check. These fees may change—Fees are adjusted annually on July 1st to reflect changes in expenses.

Please Note: **You must *cancel* scheduled appointments one business day/24 hours in advance; otherwise, we will bill you for half the normal session fee, even if the cancellation was unavoidable.** If you do not use your full appointment, you will be billed half fee for the portion you did not attend.

Fees for ***telephone calls, email consults,*** services not considered medically necessary, attendance at meetings with other professionals you have authorized, preparation of records or summaries, or minimum of 10 minutes (1/5 hour). These services normally are not covered by health insurance. Also, if I am subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony. Billing fess for ***court related work*** will be two times the hourly rate, for a minimum of four hours. Cancellation for court related work is required two business days/48 hours in advance to avoid a late cancellation fee. ***Psychological testing*** is charged at the hourly rate for administration, scoring, and report writing.

I require payment for services at the time of service unless you have a health insurance company that requires a different arrangement. Payment for reports and court related work is required at the time of the request. A late payment fee of 1.5% per month will be added on any balance after 60 days. The fee to process a returned check is $30.

If you would like us to bill your health insurance company, I would ask you to sign our Insurance Information and Authorization Form.

Confidentiality: You have privileged communication under the laws of Washington. That means with some exceptions, anything you disclose in therapy and information we obtain about you from any source, even that you are a client, is confidential and can be disclosed to others only with your written authorization. However, disclosure ***without*** your consent or authorization can be made, or may require by state or federal law, if the disclosure is:

- To a federal, or state law enforcement agency requesting information for health oversight activities or as required by law;
- To proper authorities if we should have reason to believe that a child or vulnerable adult has been abused, exploited, or neglected, if we feel you are of danger to yourself or others, or if you make an actual threat against a reasonably identifiable person;
- To the courts or other party if under a valid subpoena or court order;
- To licensing boards if we are under disciplinary investigation;

- To the WA Department of Labor and Industries or ID State Insurance Fund and your employer if the services we are providing are relevant to a worker's compensation claim you have filed;
- To public health care authorities for notifiable health conditions unless the condition notification has already been made;
- To county coroners and medical examiners for the investigations of death;
- To a health care provider or facility for the purpose of coordination of care, unless you instruct us not to do so; or
- To immediate family members unless you instruct us not to do so.

Additionally, I may disclose relevant information if you file a lawsuit against me or if you commit a crime on the premises. If disclosure is required without your authorization, I will attempt to discuss the situation with you to clarify options and look for alternate solutions. In that case, I will limit my disclosures to that minimally necessary.

Other Limits to Confidentiality: For both clinical and administrative purposes, such as scheduling, billing, and quality assurance, Dr. Volwiler who shares space with me may have information about you. I also have a contract with Mallory Anderson, Paradise Billing Services who may have information about you. Both of these individuals are legally, contractually, and ethically bound to protect your confidentiality.

In the case of relationship or family therapy, or when **multiple family members** are seen by the same therapist, I assume confidentiality to be waived among participants unless other prior arrangements are made.

In some cases, it might be useful to your therapy for us to discuss your situation with others such as a physician; in that case, I will seek your written authorization for this exchange of information. Please be aware that after I release information, with your signed consent, I will no longer have control of how that information is controlled or distributed.

Several mental health care providers share emergency call with me. I will share your name and other clinical information with them only to the extent necessary to provide adequate emergency coverage for you. Additionally, I occasionally may find it helpful to consult about a case with other professionals. In this case, I will make every effort to avoid revealing your identity. Those consultants, of course, also are legally bound to keep your information confidential. I will note any consultations in your clinical record.

Treatment Records: I keep records of the service I provide you. You may ask to see or obtain a copy of those records, and you may ask to amend those records. You may be charged an appropriate fee for time and costs involved with any information request. Payment is required at the time of request. Please see the Notice for further rights regarding your records.

I keep a commingled clinical record of my work when I see **couples or families.** However, any release of information you request will apply only to sessions in which you were seen individually. I require a release from both parties for records involving joint sessions.

Therapy with Children: In the case of children **under the age of 18**, the parent(s) or legal guardian holds the communication privilege. This means that the parent is entitled to information about the child and is the person who authorizes any release of information about the child.

However, I ask that you waive your right to access to your child's treatment record. I will discuss with the parents the child's general progress and specifics if indicated. I will attempt to act in the child's best interests in deciding to disclose confidential information without the child's consent.

I require that each parent agree that you will not involve our work with your children in any legal disagreement between the two of you. In particular, by signing this agreement, you agree that in any such proceedings neither of you will ask me to testify in court, whether in person or by affidavit. You also agree to instruct your attorneys not to subpoena us or our records or to refer in any court filing to anything we have said or done.

Client Rights: HIPAA provides you with several new and expanded rights with regards to your Clinical Records and disclosures of protected health information. These include the rights to request restrictions on what information from your Clinical Records I disclose to others; requests an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determine the location to which protected information disclosures were sent, have any complaints you make about my policies and procedures recorded in your records; and obtain a paper copy of this Agreement, the Notice, and our privacy policies and procedures. I am happy to discuss any of these rights with you.

Telepsychology: Telepsychology includes the transmission of information in any electronic form, including telephone contact and email. You need to be aware that both telephone and especially email contact is ***not secure*** and involves potential risks to confidentiality. If you prefer and your system allows, I can help you use encryption with me to better protect your confidentiality.

> ***Email:*** Email is becoming an easy and fast way to communicate and handle routine questions such as those regarding scheduling or billing, and my office may use electronic communication for administrative purposes. If you contact me, please put an identifier such as "Appointment" in the subject line. Also, please remember to put your name in the body of the message.
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> Any email I send to you or receive from you will become a part of your clinical record.
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> Email is ***not*** a good medium for sending clinical information. It is not secure. Please call me if there is personal information you need to tell me, if there is any urgency to your communication, if I have not responded within three working days, or if my response is not sufficient for your needs.
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> ***Telephone:*** If I conduct therapy sessions with you by telephone, you must be aware that this is considered an innovative treatment because of limited research on therapy using this modality. Further, because I lack visual feedback, I could miss cues or information that I could normally use in our work with you. There also may be risks if our communication becomes disrupted.

Contacting Me: I am often not immediately available. In emergencies, you can try to call me through my phone number. If you cannot reach me, or you fell that you cannot wait for me to return your call, you should contact your family physician, call First Call for Help at (509) 838-4428, call 911, or go to the Emergency Room at your nearest hospital.

Concerns and Complaints: If for any reason you should have a concern or complaint about the services I deliver, ***please let me know.*** You also have the right to submit a complaint to the ***Washington*** State Department of Health, Health professions Quality Assurance, PO Box 47860 Tumwater, WA 98501-7860, (360) 236-4700.

Client Agreement: When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless we have taken action in reliance on it; there are obligation imposed on me by your health insurer in order to process or substantiate claims made under your policy; or you have not satisfied financial obligations you have incurred.

I have ready and I understand and agree to the above-stated policies. (If you have any questions, please ask before signing.)

Printed Name	Client/Legally Authorized Signature	Date
Printed Name	Client/Legally Authorized Signature	Date

I have discussed this Agreement with the client:

Therapist Signature	Date

Notice of Privacy Practices

Acknowledgement

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access your information.

By signing below, I acknowledge having been provided a **Notice of Privacy Practices.**

Client or Legal Authorized Signature	Date
Client or Legal Authorized Signature	Date