

Carrie Sheppard, M.Ed.

Licensed Mental Health Counselor

27023 164th Ave SE, Suite 109 Covington, WA 98042

(253) 859-3505 Fax: (253) 639-7145 Email: carrie@mindsourcecenter.com

MindSource Center: 253-639-7146

Office Policy Agreement

Description of Psychotherapy Services	Fee
Individual psychotherapy, 50 minutes	\$130
Extended psychotherapy session, 75 minutes	\$180
Psychotherapy initial diagnostic session, 55 min	\$160
Late cancellation/Missed appointment fee	\$60
Returned check fee	\$40

Specialized Services	Fee
Package A	Call
Package B	Call
Package C	Call
RDA hourly rate –Additional Services	\$150
International RDA- Additional RDA Charge	Call

■ **APPOINTMENTS AND CANCELLATIONS:** All sessions are arranged by appointment. Please be prompt to best use the time reserved for you: sessions cannot be extended if you arrive late. To facilitate scheduling, twenty four hour notice is required for cancellations and reschedules. Monday appointments require notification before 5:00 p.m. the preceding Friday. You will be charged at the rates listed above for missed appointments without prior notification. Please be aware that insurance companies will not reimburse for missed sessions, making you responsible for the entire fee.

■ **TELEPHONE/MESSAGES:** Messages may be left on my voice mail at (253) 859-3505. Due to the nature of an outpatient 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.

■ **FEES/PAYMENT:** My fees are listed above. Your co-pay is required at the time of service. If your insurance coverage requires you to pay a co-insurance, you may either pay at the time of service or you may be invoiced. I will bill insurance companies directly, unless you request otherwise, and provide you with a monthly statement to keep you informed of the insurance payments and/or outstanding balances. Unpaid balances more than 90 days past due will be charged a 18% interest rate (1.5% monthly). Accounts more than 180 days past due will be referred to collections. Any collection legal fees or costs necessary to collect unpaid balance will be your responsibility. When you provide a check as payment, you authorize us to use information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. You authorize us to collect a fee of \$40, plus any bank fee charged to us, through electronic fund transfer from your account if your payment is returned unpaid. Please include the following information on your check: drivers license number, full name, address and phone number.

■ **INSURANCE/MANAGED CARE:** I participate in many plans, but not all. It is your responsibility to follow any plan requirement that applies to you including co-pay amounts and deductibles. I recommend you clarify with your insurance company the specific benefits provided under your insurance plan and to follow any plan requirements that apply to you. For example, some plans require that you obtain an authorization/referral from your insurance/managed care company prior to your first session. Most plans limit the services for which they will reimburse. If you request or agree to a service for which reimbursement is later denied by your insurance company or its agent (i.e. not pre-authorized, considered medically unnecessary, beyond the benefit limit, etc.) then you assume the responsibility for paying the entire balance.

■ **CONFIDENTIALITY:** All issues discussed in the course of therapy will remain in the strictest of confidence except those for which you may choose to sign a release of confidential information (e.g., for your medical doctor, other treatment provider, or family member). Also, your insurance company or its agent may have the right to audit your records for the purposes that may include but not be 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. In the course of clinical consultation, your case information may be discussed with other professionals. However, this is done without revealing any information that would identify you. Exceptions to confidentiality, as provided by law, are explained in the Washington State Department of Licensing 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.

■ **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 own professional practice.

Education, Training, Experience, and Approach to Therapy

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 Minnesota, B.A. in Psychology, 1982.
Boston University, M.Ed. in Counseling Psychology, 1985.
Boston Institute for Psychotherapy, Advanced Clinical Fellowship, 1990.
RDI® Certification, Connections Center, Houston, TX, 2004.

LICENSE: State of Washington Licensed Mental Health Counselor #LH00003921
State of Washington Child Mental Health Specialist

EXPERIENCE: Provided psychotherapy services to individuals and families, Boston/Cambridge, MA, 1984-87.
Child & Family Psychotherapist, private mental health clinics, Salem/Beverly, MA, 1987-91.
Psychotherapist, clinic settings, Washington state, 1991-1997.
Psychotherapist, private practice, Washington state, 1992-present.

My approach to treatment is based primarily on traditional psychodynamic principles. This includes offering a safe, respectful, and supportive environment in which you may talk about your life, both past and present, and seek to understand with greater clarity and depth the concerns that have brought you here. I may invite you to share information about your relationships, experiences, family background, and personal history. This will give us a framework to learn about your particular needs and your unique way of coping with life's challenges. My goal as I learn about you is to assist you to use your inner resources more fully, and to be empowered to pursue solutions that are effective for you. Each course of treatment is unique to those who participate in it, and thus your counseling will be a blend of what you and I do together. I am responsible for developing and implementing a course of treatment that will most effectively deal with your issues. You are responsible for your decisions and for changing. Effective treatment and accurate assessment depend to a significant degree on your openness, commitment to change, and collaboration. Much of the responsibility for a successful outcome is yours. In this regard, it is always appropriate to ask questions regarding the nature and course of treatment.

My approach to therapy, when working with parents of children on the autism spectrum, is primarily from a psycho-educational standpoint. That is, important information about child development and your child's specific developmental needs is discussed within the context of formulating a plan that you will carry out at home. In addition to using traditional psychotherapy methods, I use an RDI approach to address relationship development, issues or other approaches, such as cognitive-behavioral therapy, to address co-occurring conditions such as anxiety, depression, and cognitive processing difficulties. I may utilize traditional play therapy or other specialized techniques and approaches when working with your child, as may be appropriate. Please feel free to ask questions, as it is always appropriate to inform yourself regarding your child's therapy process and the therapist's reasons for the selection of any particular technique to address therapeutic goals.

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 Caroline R. Sheppard, M.Ed., to render mental health services to (patient's name), _____. A copy of this Disclosure Statement, as well as the Washington Department of Licensing brochure has been provided to me.

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

Parent _____ Date: ____/____/____

Witness _____ Date: ____/____/____

Caroline Sheppard, M.Ed., WA State License #LH00003921

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND PRIVACY PRACTICES: I have received a copy of the federally mandated Notice of Privacy Practices.

SIGNATURE: _____ Date: ____/____/____