Molli Marie Wilson, PhD
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Office Policy and Health Care Provider Disclosure Form

Training and Approach to Treatment: I received my Ph.D. in clinical psychology from Seattle Pacific University in 2002. I also earned a Master's degree in clinical Social Work from Columbia University, New York, New York (1988). I graduated with a Bachelor's Degree in Social Work from Boise State University, Boise, Idaho (1986). I am a licensed Clinical Psychologist in the State of Washington #PSYC.PY00003780. I have been in practice since 1988, and my experience includes working with the treatment of adults, children and adolescents. I am a solo practitioner who means that although I share a space with other mental health practitioners, I am not in partnership with, nor an employee of anyone in this office.

I am a member of the Washington State Psychological Association (WSPA). I adhere to the Code of Ethics of APA. I am committed to the highest standards of professional practice as mandated by Washington State Licensing Law administered by the Washington Department of Licensing. I am a member of the Society for Child Development and Research. My area of research and subsequent dissertation is on aggressive and peer rejected children and family factors.

As a Clinical Psychologist, my education, training and approach to therapy is based on the “scientist-practioner model”. Although I primarily utilize cognitive-behavioral therapy (CBT), I may also include a combination of theoretical “evidence based” interventions. Each therapy is unique to those who participate in it. The process may be long term or short term, and usually involves exploring past/current family and personal relationships patterns. With certain childhood disorders, a behavioral approach is generally required coupled with family therapy. The therapy will focus on how you interact with those relationships as well as working together to identify habitual patterns and interactions that are troublesome to you or "dysfunctional". I am responsible for developing and implementing a course of treatment that will effectively deal with your issues. I cannot guarantee that specific changes will occur as a result of treatment. The rate of recovery and change depends on you. Together we will uncover that process. I would like you to know that I enjoy being a therapist and I am excited to be a part of your process towards change and resolution of those things that trouble you.

Risks and Benefits: Therapy can have benefits and risks. Since the process of therapy often involves discussing unpleasant aspects of your life you may experience uncomfortable feelings. On the other hand, research has shown that discussing such feelings leads to better relationships and reduction in feelings of emotional distress and creates changes in the brain.

Your Rights as a Client: In addition to this document, you received my *Notice of Privacy Practices* which describes how I might use and disclose your health information .As my client and a patient, you have privileged communications under the laws of the State of Washington. You may waive these rights by signing a "*Release of Information" form* in the event that I may wish to communicate with your physician, teacher, or former therapist. If you have been directly been referred to me, I may, as a good business practice, acknowledge that you have made contact with me, and thank the referring party. Please know, that all insurance companies expect that I will coordinate your care with your primary physician and any other physician involved in your care. If you choose to e-mail me regarding appointments or clinical information you should know that I cannot

guarantee confidentiality for any information transmitted via the internet. Please read both of these forms carefully and discuss any questions you may have with me.

Legal evaluations and or opinions: I do not provide **legal evaluations or opinions** of any kind. Please know that if your child is seeing me in therapy, and you are in a custody dispute now or in the future, I will not provide statements of any kind for either side. To provide both therapy and opinion at the same time presents a conflict of interest and would violate my ethics as a psychologist. If you are currently involved in litigation of any kind, you must disclose that to me at the time of intake. I understand and have read Dr. Wilson's policy on rendering Legal Opinions ________ (please initial).

Appointments and Fees: Therapy appointments are 45 minutes in length; the remaining 15 minutes are reserved for chart notes and billing your insurance company. This therapy time is set-aside for you. If you miss a session without canceling and/or cancel with less than 24 hours notice; you will be billed the **full amount** for that session (not just the co-pay). Insurance companies do not pay for missed appointments. If you are late for a session you will be seen for the time remaining in that session. Please pay the missed appointment fee charge at your next scheduled session. My **billing address is: P.O. Box 646, Maple Valley, Wa. , 98038.** Please remember that *you are ultimately responsible for payment*, not the insurance company. Out of business courtesy, I will bill your insurance company .I do not bill secondary insurance. I charge $25.00 per check that the bank deems non-sufficient funds. My standard fee for a therapy session is $200.00 for initial intake, and $150.00 thereafter. If I am a contracted provider for your insurance company, I have agreed to the conditions of that contract. . If I **not** contracted with your insurance company, I am not subject to any contractual obligations. **I expect that you will pay the portion that insurance does not pay at each session, e.g. deductible, co-payment or a percentage.**

Letters, treatment summaries and consultation: If you request that I write a **letter** for you, I will charge you at my *hourly rate* with a minimum charge of $75.00. Similarly, if you request that I peruse past **records in your behalf**, I charge my hourly rate. If you request that I send records or a summary of treatment to another health care provider, I will charge the usual fee for a basic office visit plus a copying fee (WAC 246-08-400). If I attend a **meeting** in your behalf, I will charge my hourly rate plus travel time.

Phone Calls: If you are experiencing an emergency, please go to the local emergency room, or call 911. If you need to speak to me in the event of an emergency during office hours or AFTER OFFICE HOURS, please contact me at 206-579-8968. I will call you as soon as I am able. **Phone calls that exceed 5 minutes** will be charged at my hourly rate. Similarly, if you request that I **consult with another professional in your behalf,** I will charge you for that phone call at my hourly rate. Insurance companies do not pay for phone calls of **any** kind.

Client Consent to Treatment: I have read Dr. Wilson's Health Care Provider Statement and understand it. I consent to the use of a diagnostic statement to my insurance company and to the release of pertinent information necessary to complete the insurance/billing process. I consent that Molli Wilson may leave a phone message regarding my treatment. I consent to therapy under the terms described above with Molli Wilson, PhD and understand that I have the right to terminate therapy at any time.

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Signature/Date Molli Wilson, Ph.D.