

REDMOND REAMS, Ph.D.

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STATEMENT OF OFFICE POLICIES FOR PSYCHOTHERAPY OF CHILDREN

Welcome to my practice. Please take a few minutes to review my policies and procedures. This information introduces you to my practice and may help answer questions you may have. If you have further questions after reading this or individual concerns not covered here, please feel free to ask me about them at any time. I am in the independent practice of psychotherapy. Although I share office space with other practitioners, we are not in partnership together, we are not practicing in association with one another, and we do not supervise each other's work.

Credentials. I earned a Ph.D. in Child Clinical Psychology from the University of Washington in 1987. I also earned a postgraduate diploma in Infant Mental Health from the London School of Infant Mental Health (Denver extension) in 2001. I am adjunct faculty at Pacific University's Graduate School of Professional Psychology, Portland State University's Department of Counselor Education and OHSU's Division of Child Psychiatry. I have been a therapist for children and adults for over 25 years.

Risks and benefits I use therapy methods that research and my experience have shown to be effective with most but not all clients. Thus, I can not guarantee positive results. External factors, such as events in the child's life or irregular attendance, can interfere with the child's progress. In addition, at times, therapy can also lead children to show more acting-out behavior for a time as they are dealing with painful feelings. Please feel free at any time to raise your questions or concerns about the treatment I am providing.

Confidentiality The information you share with me or your child shares with me is considered private and confidential and will not be shared with anyone unless you have given written permission first. It is your choice whether or not to give permission. As a parent of a client rather than a client yourself, what you tell me will be covered under your child's confidentiality. This confidentiality has exceptions when information may be shared without your permission:

- if I am subpoenaed to testify in court,
- if I receive first-hand information about harm done to a child or elder,
- if you tell me or I come to believe that you or someone else will be harmed,
- if a noncustodial parent requests information,
- if you or your child commit a crime against me,
- if you fail to pay your bill,
- if your child's welfare appears in imminent danger.

Attached is a Notice of Privacy Practices. This notice explains the Health Information Portability and Accountability Act (HIPAA), a federal law that provides privacy protections with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations.

Fees My fee is \$170 per 50-minute session. I will expect some payment at the time of sessions unless

otherwise agreed to. Brief phone calls with clients will not be charged for nor will there be a charge for consultation calls with other professionals (e.g. a physician, another therapist), however, if a call with a client exceeds 15 minutes I will charge a prorated portion of my standard fee.

If you have insurance, I am willing to bill your insurance. Please help me bill your insurance by completing the attached forms. If your insurance company reimburses me for the services provided, these payments will be added to the amount you have paid at each session. If your share of my fee and the insurance reimbursement exceeds \$170 per visit, then you are due a refund from me. If your share of the fee and the insurance reimbursement is less than \$170 per visit, then you are responsible to pay the remaining amount.

Insurance companies and insurance policies vary in the coverage of psychotherapy, rate of payment, total amount they will pay, and size of deductible. It is a good policy for you to investigate your policy so that you know what the insurance will pay and what will be your financial responsibility. I will not attempt to keep track of your deductibles or benefit limitations. Clients sometimes decide they want to have more therapy sessions than insurance will cover. If you use your insurance, then I must send the insurance company a psychiatric diagnosis and often other information which they require.

Appointments. My major asset is my time and experience. My preference is to have a regularly scheduled appointment which both of us will try to not cancel because of other appointments. In life, however, unpredictable events occur. Clients are asked to give 24 hours advance notice in canceling appointments and will not be charged for such canceled appointments. ***If less than 24 hours notice is given, the fee of \$85 will be charged regardless of the reason. If you do not show for an appointment and have not cancelled, then the full fee of \$170 will be charged*** (NOTE: Insurance companies do not pay for cancellations or appointments that are not kept). My voicemail is available 24 hours per day, seven days per week (299-4492) and will record the time of your call.

Emergency Procedure In case of an emergency, call my emergency line (503-422-3574). If I do not answer, please leave a message and I will call you back as soon as I am able. If you can not wait for a call back, please call the Multnomah County Mental Health Crisis Line at 503-988-4888 or dial 911 or go to the nearest hospital emergency room.

Consent for treatment By signing below, I authorize Redmond Reams, Ph.D. to provide therapy using protected health information to _____. I understand that I am also assuming ultimate financial responsibility for the cost of the treatment. I also agree that I have had the opportunity to discuss the potential benefits and risks of the therapy to be done by Dr. Reams. This consent can be revoked at any time in writing. Your signature below also serves as an acknowledgment that you have received the HIPAA notice form described above.

Signature of client or guardian

Date

Redmond Reams, Ph.D.

Date