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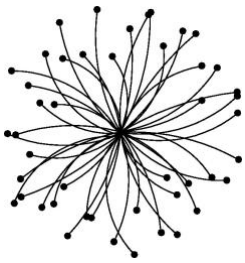

PSYCHOLOGIST-PATIENT SERVICE AGREEMENT CONSENT FORM

Welcome to my psychotherapy practice! I am pleased to have the opportunity to work together. This document outlines important information about my professional services and business policies to help you in deciding about our work together. Please read the following agreement carefully so you understand my business policies and procedures. I will also provide you a Notice of Privacy Practices following the Health Insurance Portability and Accountability Act (HIPAA). Note that my psychotherapy suite may include other mental health professionals unrelated to my business. I am an independent practitioner solely responsible for the care of my patients.

TREATMENT APPROACH

I am a licensed clinical psychologist (#PY60743633) working with adults of all ages who bring a variety of concerns to psychotherapy for exploration, understanding, and relief from suffering. I approach psychotherapy collaboratively and consider the therapeutic relationship a vital aspect of the change and healing process. I practice psychotherapy from a relational psychoanalytic perspective, which focuses on understanding how past relationships and experiences influence the way you make sense of and interact in the world today.

In our work together, you can expect to explore themes in your life, beginning with your initial reason for pursuing treatment. While we will work to alleviate your immediate distress and find solutions that respond to your pain and suffering, our greater shared goal is to create lasting change. You can expect us to explore your most recent experiences in the world, but also your past. Our earliest experiences and relationships shape who we are in the world—how we make sense of ourselves, how we regulate our emotional experiences, what we anticipate will happen to us, how we relate to others. The relationship between you and I will also be informed by these experiences and expectations. And so we will use our understanding of each other to make sense of it all and to build and develop the changes you want to have and experience.

Your experience in psychotherapy will depend on your participation and engagement in the treatment process. From the beginning, you will be an active contributor in identifying your goals for treatment, but also in describing your experiences living in the world, your own formulations for how and why difficulties are emerging or being maintained. Your participation will help shape the course of treatment and the outcomes you want to obtain. You are encouraged to bring up your questions or concerns about treatment, including treatment plans and goals, at any time.

EDUCATION & TRAINING

My educational background includes a doctorate degree in clinical psychology with advanced, ongoing training in psychodynamic theory and relational psychoanalysis, two areas of psychology that focus on understanding how the past informs the present. Additionally, I hold a master's degree in psychology with

specialization in art therapy. I offer the use of art with patients interested in incorporating a creative approach to self-discovery and self-awareness.

My current practice specialties include issues related to anxiety; depression; family of origin work; gender and sexuality; grief, loss, and mourning; identity development; life changes and transitions; personality issues and self-defeating patterns; interpersonal relationships; stress management; and recovery from trauma/PTSD, especially adult survivors of childhood abuse.

DR. MUCCI'S RESPONSIBILITIES TO YOU

Psychotherapy is a relationship within a specific framework that includes clearly defined rights and responsibilities held by each person. These rights and responsibilities help manage the risks of psychotherapy with the goal of supporting your growth and change.

CONFIDENTIALITY
Your right to confidentiality is of the utmost importance. To that end, no information about you is released to anyone without your written permission, except as required by law. Limitations of such client held privilege of confidentiality exist and are detailed as follows:

1. Suspected abuse and/or neglect of a child, developmentally disabled person, or a dependent adult
2. Potential suicidal behavior or behaviors that risk serious bodily harm
3. Threatened violence or harm to another person
4. When required by court order for information as specified by a subpoena
5. Impairment of other licensed health care professionals governed by WA Department of Health
6. See all other uses and disclosures of protected health information in the Washington State Privacy Notice

Additionally, I participate in regular consultation meetings for my professional development, which may include sharing information about our work together. Under the provisions of the Health Care Information Act of 1992, I may also legally speak to other health care professionals about your treatment, although I will always attempt to get your permission first.

Protected health information (PHI) is also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you.

RECORD-KEEPING
I maintain written records about your treatment, which includes messages you send me via text or email outside our sessions. I utilize a HIPAA compliant, secure, electronic health record and billing system for health care professionals called SimplePractice. Your records are maintained on a password protected and encrypted server under the provisions of the Health Care Information Act of 1992 (see WA State Privacy Notice).

In addition, I may keep separate psychotherapy notes for my own learning purposes. These notes are used only by me and will not otherwise be used or disclosed without your written authorization unless required by law.

YOUR RESPONSIBILITIES AS A THERAPY PATIENT

APPOINTMENTS AND CANCELATIONS
You will be involved in setting your appointment time. Once established, your weekly appointment is reserved just for you, unless you have made other arrangements with me. Good therapy outcomes depend on your engagement and regular participation in treatment. For that reason, I reserve your appointment time exclusively for you and typically meet with patients on a weekly basis. A regular psychotherapy session includes 50 minutes face-to-face. You are responsible for coming to your session on time and at the time scheduled.

Please provide 48-hours advanced notice of cancelations. If 48-hours notice is not given, regardless of the circumstances, you will be expected to pay the full amount for the session out-of-pocket. Please note, I cannot bill insurance for the time that we are not meeting face-to-face or via telepsychology; insurance will not cover the missed session. I will send you an invoice for the missed appointment and payment will be due before your next appointment.

The cancelation fee is waived if we are able to make accommodations to meet via telepsychology (in lieu of in-person appointments) or if our regularly occurring appointment can be rescheduled within the week, dependent on my availability.

You are not charged for sessions when I am unavailable because of a preplanned or unexpected absence. I take vacation a few times a year and observe most Federal Holidays. I will inform you in advance of my planned time away from the office.

PAYMENT & INSURANCE
Your insurance may cover a part of the cost of therapy. It is your responsibility to determine coverage by calling your insurance company prior to treatment. If I am an in-network provider with your insurance company and you wish to use your insurance, I will bill your insurance company directly. I file these claims as a courtesy and try to help with problems, but you need to resolve those beyond my control. You will be responsible for any difference between what is charged for services and what your insurance company pays. If I am not in-network with your insurance company, you will be responsible for paying the full fee for services at the time of your appointment and submitting claims to your insurance company for reimbursement.

The portion of payment you owe will be due upon invoicing. I submit claims to insurance regularly and invoice monthly. Please inform me of any changes to your insurance as soon as you become aware of them to avoid unexpected changes to coverage and your owed amount. If you elect to pay for sessions out-of-pocket, without any insurance, full payment is due at the time of service.

Your account must be paid in full within 30 days.

FEES
My fee for the first diagnostic assessment appointment is $225. My fee for subsequent appointments is $175. I reserve the right to change my fees and will inform you in writing of any changes that occur.

In addition to scheduled appointments, it is my practice to charge $45 per 15 minutes for other professional services that you may require such as telephone conversations lasting longer than 15 minutes and preparation of records or treatment summaries, including reports requested by your insurance company, if applicable. Any time spent testifying in court will be charged at twice the standard fee including travel time.

TERMINATION

Under most circumstances, terminating and/or graduating treatment will be a mutually agreed upon decision set up ahead of time. However, it is your right to refuse or discontinue treatment at any time. I may also terminate treatment, in discussion with you, if I determine that treatment has become ineffective or iatrogenic, or if I become aware that I am unable to provide adequate and effective treatment. I may terminate therapy if you are in default on payment. If you threaten, verbally or physically hurt or intimidate me, if you harass me, or ask me to engage in any illegal conduct you will be unilaterally and immediately terminated from treatment without further contact. In all other circumstances of termination, I will provide you with appropriate referral sources as necessary.

Lastly, if you fail to schedule an appointment for three consecutive weeks, I will assume you have discontinued treatment and will terminate our treatment relationship.

NOTICE TO PATIENTS

If you have any concerns or complaints about your therapy, I hope you will bring them directly to me so that we may attempt to repair and resolve them.

Patients of licensed or registered therapists in the State of Washington may file a complaint with the Department of Health at any time if they believe a therapist has demonstrated unprofessional conduct. To obtain a list of actions considered to be "unprofessional conduct," or to file a complaint, contact:

Department of Health
(360) 236-4700

Health Systems Quality Assurance Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857

ACKNOWLEDGEMENT SIGNATURE

Your signature below indicates that you have read, fully understood, and consent to treatment. It also services as acknowledgement that you have received the HIPAA Notice of Privacy Practices. Once you have signed this page, your signature signifies that you understand your rights and responsibilities in therapy and it constitutes your agreement to the terms described in this document.

I have read the above policies on confidentiality, patient's rights, billing and insurance procedures and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself.

_____ _____

Signature of Patient Date

_____ _____

Signature of Therapist Date