

**Claudette C. Granahan, Ph.D.**

Licensed Clinical Psychologist

North Park Building  
12356 Northup Way, Suite 105  
Bellevue, WA 98005  
Voicemail: 425-861-4477

**OFFICE POLICY AGREEMENT**

Welcome! Effective psychological treatment requires openness, an attitude of collaboration, and your willingness to invest both time and effort between sessions in working toward personal change. The success of treatment cannot be guaranteed because the outcome depends significantly upon your actions. I will utilize my experience and education to work with you, and will perform my services in a professionally competent manner.

**PARTIES TO THE PROFESSIONAL RELATIONSHIP**

The professionals in this suite of offices share only the physical facilities. Each of our practices is separate and independent from one another. Therefore, this agreement is entirely between you and Claudette C. Granahan, RN, Ph.D., a licensed clinical psychologist practicing independently. Please take time to carefully read this agreement so that you may better understand your rights and responsibilities.

**APPROACH TO TREATMENT**

My approach to therapy, and its length, will depend on your particular needs and goals. I believe that problems can be identified, and needed changes defined, in a straightforward and understandable manner. I view most problems as having multiple contributing causes (e.g. environmental and/or interpersonal stressors, behavioral and/or physical factors, etc.) If you have any difficulty understanding the therapeutic process, I welcome your questions. Please feel free to ask about the strategies I am using or the expected outcome of therapy.

My training includes a Bachelor's degree in psychology from Seattle University, a Master's degree in Systems Counseling from the Leadership Institute of Seattle (LIOS), and a PhD in Clinical Psychology from Pacifica Graduate Institute. I am also a Licensed Clinical Psychologist in the State of Washington. I have been in private practice since 2004. My prior experience was 7 years with Seattle Mental Health as a psychotherapist and as a psychology intern working with individuals, couples and families.

*“Psychologists practicing counseling for a fee must be licensed with the department of health for the protection of public health and safety. Registration of an individual with the department does not include a recognition of any practice standard, nor necessarily implies the effectiveness of any treatment.”*

## CONFIDENTIALITY

All information you disclose is considered confidential and will not be released without a Release of Information form signed by you. The law requires disclosure of confidential information, and reporting to authorities in three situations: Suspected abuse of children or incapacitated adults, threatened harm to self or others, or if individuals are gravely disabled and not able to care for themselves. In some instances confidential information can be subpoenaed by court order.

The above confidentiality information may not apply if you are using a managed care company. When your insurance is handled by a managed care company, I may be required to disclose personal information to the company so it can decide about treatment necessity; this may limit your right to confidentiality. If you have concerns about these limitations on your right to confidentiality, please discuss them with me.

In providing therapy services to minors, the custodial parent(s) is (are) the “holder” of the privilege. In the treatment of minors, the best course is to discuss the limits of confidentiality at the outset in order to reach an agreement that is acceptable to both the parent(s) and the child, and that will allow effective treatment to occur.

If you are seeing me in couples or family therapy, and you, your partner or another family member should happen to see me in an individual session, information shared with me in that meeting may be shared by me in a couple or family session if I believe it to be in the best interest of the work we are doing together. I will discuss this matter with you before sharing that information.

If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner) I will not release any information to a third party (court, attorney, etc.) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents agreement to this requirement. If this concerns you, please bring it up the next time we meet together.

In some cases, it will be useful to the therapy for me to discuss your situation with others such as your physician, your former therapist, your attorney, etc. In such cases, I will seek your written permission for this exchange of information.

I do consult with colleagues regarding my work with clients to gain feedback and suggestions about treatment. My work with you may be discussed in formal or informal sessions with my colleagues or with other professionals. During these consultations, neither your last name nor any other unique identifying information will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above.

If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to them that you have contracted with me for services and I will thank them for the referral. I will not discuss your situation with them unless I have your written permission.

You always have the right to request a change in the treatment process or refuse treatment. It is important that what we do together meets your needs. If you believe you are not being helped, please tell me so that we can work through the difficulty together. If we are unable to do so, I will assist you in finding another therapist.

Although you are free to terminate therapy at any time, it is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session. I consider it of therapeutic value to you that the counseling relationship be closed in a straightforward manner, ensuring that all counseling issues have been dealt with to the best of your and my ability. In any case, notice of termination will result in my scheduling other clients into your regularly scheduled time slot. If you cancel an appointment or miss an appointment without leaving notice of rescheduling on my voice mail, notice of termination will be assumed and your time slot will be given to the next available client.

As a Licensed Clinical Psychologist, I am accountable for my work with you. Counselors' work is governed by the Counselor Credential Act. The purpose of this law is to provide protection for public health and safety, and to empower the citizens of the State of Washington by providing a complaint process against counselors who would commit acts of unprofessional conduct. If you have any questions or concerns about the quality of my services or any administrative matter (such as fees, etc.) please discuss them with me first. I am committed to providing the highest quality professional service, managed in a fair manner. If, after discussing your concerns with me, you feel I have been unresponsive to your concerns, you may contact the Department of Health, Professional Licensing Services, PO Box 47868, Olympia, Washington, 98504-7868, (360)753-2147.

## EMERGENCIES

In the event of an emergency outside normal office hours, you should first attempt to reach me at my voicemail 206.560.1183. If I am unavailable, please contact one of the following: King County Crisis Clinic 425.461.3222; Call 911; or proceed to your local hospital Emergency Room as appropriate.

## PAYMENT POLICIES

**Payment for services provided to you is due at the time of service** unless you have subscribed to an insurance plan in which I am listed as a “preferred” provider. You are expected to pay for all services you receive, whether or not your insurance company

may eventually pay for a portion of the charges. If your plan requires a co-payment, it is payable at the time of service. If you are unable to pay the co-payment, I will be glad to discuss alternative treatment resources, including crisis intervention. My fee for psychotherapy is \$130.00 per 50 minute session. You may have additional charges for:

- Legal expenses, including testimony.
- Reports, letters, or telephone calls on your behalf to attorneys, physicians, agencies, employers, teachers, state disability, etc.
- Travel time to any location outside of my office.

Some of the above charges are not covered by insurance plans. No reports will be released on your behalf unless your account is current. A retainer fee for court or other legal purposes must be paid for prior to commencing any evaluation or treatment. At times, it may be necessary to change my fee. When I do that, I will give you two months' notice of my new fee.

#### INSURANCE REIMBURSEMENT

I strongly recommend that you check with your insurance company to see if you are entitled to receive any benefits under your plan. The filing of insurance claims is your responsibility, unless the insurance company will make payment directly to me. I do not bill secondary insurance companies, unless the plan requires direct billing. All secondary insurance billing will be your responsibility (unless the plan requires me to bill) and payment of this portion is expected at the time of service. If you subscribe to a plan that manages your benefits, some, or all, of the following restrictions may apply to your coverage.

- Pre-authorization for treatment may be required.
- Your choice of therapist may be limited.
- The number of sessions may be limited.
- Re-authorization may be required.

You are responsible for knowing what your benefits and restrictions are, and how much treatment will be covered. If your insurance company does not pay for a therapy session because you did not know your benefits, you will be responsible for covering the cost of the session. The inclusion of these limits is unfortunate, but please be aware that the insurance company, or its managed care company, imposes these limits. I do not.

#### APPOINTMENTS

Individual therapy sessions are 50 minutes in length. It is important to be on time because your appointment will not be extended beyond the scheduled time if you are late arriving. I hold your appointment time exclusively for you. If you are unable to keep your appointment for any reason, I require 24-hour advance notice to cancel.

OTHERWISE, YOU WILL BE CHARGED THE FULL AMOUNT FOR THE TIME RESERVED FOR YOU. INSURANCE DOES NOT PAY FOR LATE CANCELLATIONS OR MISSED APPOINTMENTS.

RETURNED CHECK POLICY

You will be charged a \$25.00 processing fee for any check returned to me unpaid. This fee is not covered by insurance.

OVERDUE ACCOUNTS

You are responsible for your account and are expected to pay for all services you receive. Accounts overdue 90 days or more may be turned over to a collection agency or to an attorney. **You will be responsible for attorney’s fees and costs, or collection agency fees, in the event that your account becomes delinquent.** *Credit bureaus may be notified of your overdue account.* Accounts overdue more than 30 days may be assessed a 1% interest charge each month (12% per year).

AGREEMENT TO PARTICIPATE IN SERVICES

I have read or have had satisfactorily explained to me Dr. Granahan’s Office Policy Agreement and understand it. I have asked any questions that I had about this statement, and about statements regarding fees and payment policies. I understand and agree to the description of confidentiality and its exceptions as stated above. I consent to counseling under the terms described above with Dr. Granahan and understand that I have the right to terminate counseling at any time. I also understand that Dr. Granahan requests notice of termination at the beginning of a regularly scheduled session so that the reasons for termination may be discussed. My signature below indicates that I have received a copy of this agreement.

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Claudette C. Granahan, PhD. \_\_\_\_\_ Date \_\_\_\_\_