701 W. 7th Ave, Suite 130, Spokane, WA 99204
(509) 838-3932 office (509) 838-1163 fax

Disclosure for Evaluation

Kristin Sims-Cutler, Ph.D., Postdoctoral Resident

The following is a description of the practice policies, client's rights, fee schedule and theoretical basis for evaluation of children, adolescents, adults, and families. Please review this document in detail, as you will be asked to initial and sign a copy, indicating that you have been informed and agree with these guidelines.

Employment and Training Status:

I am currently employed part-time at ICARD, PLLC as a Postdoctoral Psychology Resident. This means that, until I am licensed in August 2018, I will be working under the license and supervision of Dr. Liz Pechous, Clinical Psychologist and co-founder of ICARD. This position includes regular supervision hours and provides you, the client, with additional support during the evaluation and therapy processes. Feel free to direct any questions to myself or to Dr. Pechous regarding my training or your experience here at ICARD, PLLC.

Education History and Qualifications:

Education History

Aug. 2014	**Ph.D.**	**Educational Psychology –** Clinical Psychology Specialty, Walden University, Minneapolis, MN
June 1996	**ESA Cert.**	**School Psychologist Certification, Washington State.** Eastern Washington University, Cheney, WA
Aug. 1990	**M.A.**	**Counseling & Guidance, School and Chemical Dependency Specialty** Pacific Lutheran University

I have worked with children, adolescents, and families for over 20 years, and across a variety of contexts including school settings, inpatient and outpatient substance abuse treatment facilities, corrections settings, hospital, and private practice settings. Common areas of focus have included general counseling, addiction evaluations and treatment, individual and group psychotherapy, psychological testing for a variety of learning disabilities and cognitive dysfunctions, pediatric behavior therapy, anxiety, depression, treatment of OCD and related disorders, trauma, and autism spectrum disorders. I have conducted full psychological evaluations across a number of settings including private practice settings and school settings, and here at ICARD, PLLC.

As a school psychologist, and as a psychology resident, I have participated in psychological evaluations that include cognitive, behavioral, adaptive, and executive function evaluations. I have specialized in treating anxiety and OCD disorders, and participated in an intensive Behavior Therapy Training Institute program for OCD and related disorders treatment at Roger's

Memorial Hospital in Occonomowac, Wisconsin. This program is affiliated with the International Obsessive and Compulsive Disorders Foundation (IOCDF).

_____ **Confidentiality:**
initials

Under the laws of the state of Washington and the Ethics Code of the American Psychological Association, anything discussed in the evaluation process and any information obtained about you or your child from any source is confidential and cannot be disclosed to others without your/your child's (if they are age 13 or older) signed consent. This communication is privileged. If you desire that I talk to someone else (your/your child's physician or PCP, for example) about an evaluation or therapy process, I will ask you (and/or your child if they are age 13 or older) to sign a release of information form that will remain a part of your file.

There are limits to confidentiality and under specific circumstances I am required by Washington State law to report information to the appropriate authorities, even without your consent. The following are the limits to confidentiality:

- Physical/sexual abuse or neglect of a minor (under 18 years old).
- Physical/sexual abuse or neglect of an adult dependent or developmentally disabled adult.
- Threat or intent of clear and imminent danger to the health or safety of yourself or others.
- If you decide to bring a civil suit against someone. In so doing you waive all rights to confidentiality. Relevant records may be subpoenaed by a court of law and they may ask me to testify concerning the nature of treatment.
- If you are submitting your bill for payment to a third party/insurance company they have full access to your records and all the information within, including but not limited to diagnosis, social security number, and evaluation. By allowing them to become a part of the payment process, you waive your rights to confidentiality specific to their services.

If any of these above circumstances occur during the course of your or your child's evaluation or treatment, I will discuss the concern with you in order to clarify the situation and to seek appropriate solutions.

In addition to the limits of confidentiality as stated above, it is important for you to know that I may discuss your case with my supervisor and other members of our clinical team. The confidentiality of minors (age 13 – 17, or older if guardianship is in place) will be respected; however, parents will be informed if their child or adolescent is homicidal, suicidal or unable to care for him or herself.

_____ **Privacy Limitations:**
initials

As part of doing business in private practice, I may communicate with agencies and individuals on my cellular phone or e-mail. I use encryption protection when communicating by email. There are no guarantees of privacy with the cellular phone or e-mail. If you do not wish to have me communicate with you or others regarding your case over the cellular phone or e-mail you must let me know, either verbally or in writing. If it is okay with you if I use a cellular phone or e-mail to communicate with you, please initial on the blank in the margin to the left.

_____ **Mutual Responsibilities:**
initials

We have responsibilities to each other in the evaluation and or therapy process. Our office sends you initial paperwork. When seeking a formal evaluation for you or your child, Step 1 (Intake)

of your evaluation is not scheduled until all paperwork is completed and returned. At this juncture, the waitlist is typically several months for evaluations. That means that this several month waiting time starts after the paperwork is fully completed and returned. It is your responsibility to call to check on where you and or your child is on the waitlist, and when the anticipated scheduled appointment will be. Approximately one month before an appointment time, ICARD, PLLC will contact you to confirm an appointment time and check if there are any changes to insurance or other information you previously provided. You will be scheduled for that initial intake appointment, which is Step 1 (Intake) of our evaluation process. For the intake, you will see Dr. Pechous or Dr. Sims-Cutler for an initial appointment (without your child if it is a child evaluation). Following that appointment, you will be scheduled for a second appointment, which is Step 2 (Testing) of our evaluation process (for additional testing (if necessary) or initial testing for you and or your child. Following that second appointment, you will be scheduled for Step 3 (Feedback) of our evaluation process, which is a third appointment. The third appointment is for a feedback session in which a written diagnostic letter or report will be provided, depending on the type of evaluation for which you have engaged ICARD, PLLC services.

Your responsibility will be to participate as much as required in the evaluation process and update ICARD, PLLC if there is a change to the original reason for evaluation, and or if additional testing requirements become necessary. For instance, it is possible that your child's school may request information that was not originally anticipated. Such an occurrence could add to our timeline since it could delay written documentation and the subsequent feedback session. It is your responsibility to inform me of such an event. Also it is your responsibility to talk to me or my supervisor, Dr. Pechous, about any concerns regarding the evaluation process along the way. Please do not hesitate to initiate questions or to contact us to discuss questions or concerns.

Depending on the time of year you initiate services, it is possible that the several month waiting period may not be completed during the same school year as when you seek an evaluation. We will make every effort to complete the requested evaluation as soon as possible, but please be aware of the timeline involved. If you feel that another service provider can better meet your timing needs, you have the right and responsibility to seek out the services of the provider you believe will best meet your and or your child's needs.

_____ **Theoretical Orientation for Evaluations:**
initials

I utilize best practices and evidence-based practices in the psychological evaluation and or therapy of children, teens, and adults. Information may be gathered from parent(s) and or guardians, caregivers and or teachers, providers, or other relevant sources to inform my best clinical judgment in conducting the evaluation for the nature and purpose required. I will use questionnaires, standardized assessment tools, and observations as necessary to accomplish this. For younger children (ages 18 months to 8 years) I may use the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) Modules Toddler, 1, 2 or 3 to look at possible Autism Spectrum Disorder diagnosis.

_____ **Payment:**
initials

For an office visit, my standard fee is billed at the rate of $100 per hour unless other arrangements have been made with you for a sliding scale rate. Your insurance carrier will likely have a lower contracted rate and copay and/or coinsurance that is required. You are only responsible for the allowable charges and your copay and/or coinsurance. ***However, if your insurance does not cover my services, then you agree to pay me directly.*** It is also important to

be away that many insurance plans require annual deductible amounts be paid, typically beginning at the beginning of the New Year. This may change the amount you usually pay until the deductible is met. We do accept debit and credit cards for payment. The initial Intake appointment is billed at $250. Co-payments are due at the time of service.

Other payment may be made in one of two ways: 1) after each session, or 2) at the end of each month when you receive a statement from us. If you itemize your taxes, the fees that you pay for psychological services that are not reimbursed by your insurance carrier(s) are usually deductible as medical expenses. Your cancelled checks, credit or debit card receipts, and fee bills are likely sufficient evidence.

_____ initials

Structure for Evaluation Appointments:

Evaluation appointments vary based on the nature and purpose of that evaluation. All evaluations follow a 3-step process: Intake, Testing, and Feedback. When ICARD is contacted for testing and evaluations, potential clients are told there is a several month waiting list at this time. Information is collected and paperwork sent out automatically. When paperwork is returned, clients are put on the waiting list. They may also have electronic links to rating scales and or questionnaires needed for the evaluation from parents, client, and or school, if applicable. Then the intake will be scheduled.

Step 1 for Evaluation: Intake is done with Dr. Sims-Cutler and/or Dr. Pechous. Based on information gathered in this step and other initial paperwork, the next steps are determined regarding the type of testing needed, and you will be contacted to schedule for Step 2.

Step 2 for Evaluation: Testing is done depending on the type of evaluation requested (see below). Step 3 for Evaluation, Feedback, is scheduled following completion of testing. Documentation will be written by a member of the evaluation team and reviewed, edited, and signed by Dr. Pechous.

Step 3 for Evaluation: Feedback session is completed with Dr. Pechous and or Dr. Sims-Cutler and the client (if adult) and/or parent(s). Findings and recommendations are reviewed with the family and questions are answered. Final signed documentation (report or diagnostic letter) and 2 copies will be provided. After feedback appointment, documentation will be sent to PCP, providers, agencies and schools per evaluation type with release given as appropriate. ***So there will be at least three appointments unless other arrangements are made for an evaluation.*** Requested type(s) of evaluation (check those that apply) for this case are as follows:

- ☐ **ADOS-2/ABA (Autism testing for young child--ages 2 -8 years or in Idaho)**
- ☐ **Diagnostic Evaluation (clarify a possible diagnosis)**
- ☐ **DDA (Developmental Disabilities Administration)**
- ☐ **Social Security**
- ☐ **Other Learning Testing (Cognitive/Academic/Memory/Learning)**
    - **for IEP/504 Plan**
- ☐ **Other—please specify:** ______________________________

_____ initials

Cancellations

It is essential that you cancel your appointment at least 24 business hours before the time of your appointment. If you do not give the required notice of your intent to cancel the appointment, you will be charged a $35 fee for the time that you reserved. If you are receiving

co-payment with insurance, the insurance company cannot be billed for any session you have missed.

_____ **Complaints:**
initials

If you have a concern or complaint about your (or, if applicable, your child's) treatment, please talk with me or my supervisor, Dr. Pechous, about it. If we cannot resolve your concern, you should be aware there is a resource for you to contact for a review of the services we have provided. This resource is through the Department of Licensing, and the address is:

Examining Board of Psychology
Department of Licensing
Division of Professional Licensing
PO Box 9649
Olympia, WA. 98504

Inquiries: 206-753-3095
Complaints: 206-753-1392

The State of Washington requires that we provide you with the following statement:

"Psychologists practicing counseling or psychology for a fee must be registered or licensed with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment."

Disclosure Statement Verification:

By signing this document, I, ______________________________ (name of client and/or parent if applicable), acknowledge that I have read the disclosure statement and have received a copy of it. I have had the opportunity to ask questions, which have been answered to my satisfaction. I verify that I have read and understand the information presented in this Disclosure Statement provided to me by Dr. Kristin Sims-Cutler. I agree to pay $100 per hour and it will be billed to ____________________ per the contracted rate or unless a sliding scale fee of $______ per hour applies. ***If insurance does not cover the fees for services, I am responsible for these charges unless there is another arrangement.***

If I cancel an appointment and give less than 24-hour notice, I understand that I will be billed $35 for that appointment as it cannot be billed to insurance. I have been shown my rights and responsibilities as a client for evaluation (or parent or guardian of a client) and agree to uphold these in accordance with the above disclosure. If I have further questions about my/my child's evaluation or the training and credentials of either Dr. Olin Bittner or Dr. Liz Pechous, I agree to address these directly with one or both of them, or alternatively contact the DOH at the above contact address. My signature indicates that my rights as a client (or parent or guardian of a client) have been clarified and that I give my informed consent for the evaluation services identified above. I understand at this time there is a 6 -9 month waitlist and it is my responsibility to call to check on where I or my child may be on the waitlist and when the anticipated scheduled appointment will be. If I feel that another service provider can better meet my timing needs, it is my responsibility to seek out appropriate alternative services I believe will best meet my/my child's needs.

I understand that services for Kristin Sims-Cutler, Ph.D. will be billed under Liz Pechous, Ph.D., at a reduced rate, until she is licensed & credentialed with contracted insurance companies.

Client Name ______________________________ DOB __________

Client signature (if 13 yrs or older) ____________________ Date __________

Parent or Legal Guardian signature____________________ Date __________

I verify that I have given my client a disclosure statement explaining the therapy process and describing our respective roles in the therapy relationship. I have answered any questions s/he has asked and agree to provide further information if necessary. I agree to uphold my portion of responsibility in the treatment of this client, as is described in the information that I have provided her/him.

Kristin Sims-Cutler, Ph.D.____________________ Date ____________________
Psychology Resident
LMHC # 7859

Liz Pechous, Ph.D. ____________________ Date ____________________
Supervising Clinical Psychologist
Licensure #PY2566