Gregory Upton, PsyD
2319 N. 45th Street #312
Seattle, WA 98103
(206) 801-1408

Therapist-Client Service Agreement

About Me

I am a graduate of the clinical psychology program of George Washington University in Washington, D.C., with experience in a variety of clinical settings, including: a residential youth-care facility, a community mental health center, community schools, a mental health rehabilitation center, and private practice. I utilize a flexible psychodynamic approach to therapy, focusing on establishing a safe environment in which individual adults and adolescents can feel secure as they address their difficulties. My work with children focuses on a style of play therapy that allows them to identify their issues in a comfortable setting, utilizing familiar toys and games, as I provide support, interpretations, and problem solving skills.

The First Few Meetings

The first few meetings are an opportunity for us to get to know each other and how we might work together. During that time, I will want to evaluate your needs in order to get a good sense how I may be of help. As we talk, I will also be able to offer you some first impressions of what our work might include. You should consider this information along with your own impressions to decide if you want to continue working together. Therapy involves a commitment of time, energy, and money so it is important for you to choose a therapist with whom you feel comfortable. You have the right to refuse treatment, and a responsibility to choose the provider and treatment modality which best suits your and/or your child's needs. If, at any point, you have any questions about me or about my work, please let me know so that we can discuss them together. If your doubts persist, we can review alternatives such as different treatment settings or referrals to other clinicians.

Appointments and Cancellation Policy

My initial consultations are 60 minutes long; regular therapy visits are 45 minutes. However, this can vary if needed. You are responsible for arriving on time for your appointment. If you are late, we will still end the appointment at our scheduled time so as not to inconvenience the next client's session. If you need to cancel an appointment for any reason, I ask that you provide at least 24 hours advance notice. A scheduled appointment means that time is reserved for you. If an appointment is cancelled with more than 24 hours notice, it can be rescheduled within the same week at no charge. If that is not possible, or for any other missed appointments, I will charge the full $190 fee. Please be aware that insurance will not cover missed appointments, therefore the full cost of a missed session is the responsibility of the client.

Fees and Insurance

You are responsible for paying for your session at the time of service unless we have made other arrangements. My fee for an initial consultation is $230 for new clients. My fee for each subsequent appointment is $190. Fees for other services, e.g., school meetings, physician consultations, etc., will be billed at $190 per hour and are generally not covered by insurance.

You may wish to use insurance to cover part of the fees for office visits. Please check with your insurer regarding coverage before your first appointment as I may be considered an out-of-network provider. Please be advised that some insurers only cover 45 minute appointments. If this is the case, you may request your sessions be limited to 45 minutes. If you would like to submit a claim to obtain out of network coverage, I can provide you with a statement at the end of each month that you may submit to your insurer. Payment for services is due upon receipt of a statement, with balances over 90 days old charged a 10% interest rate.

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Contacting Me

I can be reached by phone at (206) 801-1408. I may not be immediately available to take calls, however, I check voicemail frequently and will make every effort to return your call within 24-48 hours. The most reliable way to reach me is by phone but you may also contact me by text at the above number, or via email at Hello@DrGregUpton.com. **Note that text and email are not secure methods of communication and will be used exclusively for simple, non-time-sensitive communications such as scheduling appointments.** Please be aware that any other issues must be handled by phone or in person.

If I will be unavailable for an extended period of time, I will provide you with the name of a colleague you can contact in my absence.

Limits of Confidentiality

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about you and/or your child's treatment to others if you sign a written authorization form. However, in certain situations, I am legally obligated to take actions in order to protect you and/or your child or others from harm.

- If I have reasonable cause to believe a child under the age of 18 has suffered abuse or neglect, I am legally mandated to make a report to the proper law enforcement agency or to the state department of social and health services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult is being abandoned, abused, financially exploited or neglected, I am legally mandated to make a report to the proper law enforcement agency or to the state department of social and health services. Once such a report is filed, I may be required to provide additional information.
- If I believe that you present a clear, imminent risk of serious harm to yourself, I may be required to disclose information in order to take protective actions These actions may include contacting family members or others who can assist in protecting you, or seeking your hospitalization.
- If you have made a specific threat of violence against another or if I believe that you present a clear, imminent risk of serious physical harm to another, I may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police or seeking your hospitalization.

Further, the law allows the release of confidential information **without** your authorization in the following situations: **a)** to a person who I believe is providing healthcare to my identified client, **b)** to any healthcare provider who I believe has previously provided my identified client healthcare to the extent necessary for me to provide healthcare to you and/or your child, unless you instruct me in writing not to make such disclosure, and finally **c)** to an immediate family member or any other individual with whom you have a close personal relationship if the disclosure is appropriate within good professional practice, unless you instruct me in writing not to make the disclosure. If you are under the age of 18, I may have to share information with your legal guardian about what we discuss in therapy or during an evaluation. I will act in your best interest when disclosing information to your legal guardian. If any of these situations arise, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

If you have any questions that I haven't addressed either in this document or with you personally, please feel free to ask me for clarification at any time. I look forward to working with you.

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Agreement for Psychological Services

Client's Name: _____ Date of Birth: _____

The Health Insurance Portability and Accountability Act (HIPAA), requires that you sign this "Agreement for Psychological Services" and that I have provided you with a copy of my "Notice of Information Practices." This Policy further explains HIPAA and the protection of your personal health information. Your signature represents an agreement between us. You can revoke this Agreement in writing at any time.

I hereby acknowledge that I have received and have been given an opportunity to read copies of:

1. Gregory Upton, PsyD's Notice of Information Practices
2. The Therapist-Client Services Agreement

I understand that if I have any questions regarding these policies or my privacy rights, I can address them with Dr. Upton.

I, _____, authorize and request that my (or my child's) therapist, Dr. Gregory Upton, provide psychological services including psychological assessment, interventions and/or diagnostic procedures that now or during the course of my or my child's care as a patient are advisable. The frequency and type of assessment will be decided between client or client's parent/legal guardian and the therapist.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(if applicable)

Dr. Gregory Upton: _____ Date: _____