KENNETH A. SHULTZ EDDPS

POLICY AND PROCEDURE INFORMATION

7600 N.E. 41 st STREET, # 310
Vancouver, Washington, 98662
(360) 253-6425

GOOD RELATIONSHIPS ARE BASED ON A MUTUAL UNDERSTANDING OF EXPECTATIONS. IT IS OUR DESIRE TO BE AS CLEAR AS POSSIBLE ABOUT OUR POLICIES AND PROCEDURES.

• APPOINTMENTS:

Appointments are 45-50 minutes in length. Your appointment begins at the stated time, **not when you arrive.** If I am late you will still receive the contracted amount of time. Your appointment is held exclusively for you, therefore **absences and cancellations will be charged the full amount** unless your situation is emergent. **THUS, YOU ARE FINANCIALLY RESPONSIBLE FOR ANY NON-EMERGENT CANCELLATION ONCE THE APPOINTMENT HAS BEEN SET.** These situations will be defined in your first appointment. Non-emergent cancellations or missed appointments cannot be billed to insurance companies.

• FEES AND PAYMENTS:

You are responsible for your account and are expected to pay for all services you receive. I request that you pay at the time of each session. The fee for individual psychotherapy is **$150.00** per session and $95.00 per group therapy session. The initial diagnostic interview is **$200.00.** In addition, there may be charges at the rate of $200.00 per clock hour for:

1. administration, scoring, and interpretation of psychological tests
2. reports, depositions, or court testimony
3. collateral contacts
4. extended telephone consultations
5. diagnostic testing that includes vocational batteries, marital inventories, personality tests, psychoneurological examinations, intelligence tests, and other psychometric measures.

When possible, these charges will be discussed with you prior to the additional procedure. If you are unable to assume full responsibility for the fee payment or your insurance company pays only the provider, I will discuss the possible alternatives. Accounts that are paid in full within 30 days of termination of treatment will not be subject to interest charges of 1 1/2% per month on the unpaid balance. Other accounts will be subject to finance charges. Accounts without an acceptable payment for 90 days may be sent for collection.

• INSURANCE:

Some, but not all, insurance plans cover Mental Health Services. If you are unsure or have questions, call your insurance company to inquire if your plan covers **OUTPATIENT PSYCHOLOGICAL OR PSYCHIATRIC SERVICES.** Insured patients are expected to keep their accounts current. You are responsible for payment of your account. Under certain circumstances, I will send a bill to your primary insurance carrier for you, so that reimbursement may be obtained. In order for me to do this, you may need to provide me with your claim form and a mailing address for your insurance company. Claims are mailed at the beginning of each month for the previous month.

• GROUP THERAPY:

The fee for group therapy is $95.00 per session for each participant. Group therapy sessions are charged for by the month, non-emergent missed appointments included. In order to provide for healthy terminations, group members agree to announce any plans for termination at the first meeting of a month and to attend groups for the remainder of that month.

• CONFIDENTIALITY:

All issues discussed in the course of therapy are considered confidential. However, there are some limits to confidentiality. By law, information concerning treatment or evaluation may be released only with the written consent of the person treated or such person's parent or guardian. However, the law also requires the release of confidential information in five situations:

1. suspected child or elder abuse,
2. suicidal behavior or inability to care for yourself,
3. threatened harm to another,
4. knowledge of HIV positive and failure to inform partner,

5. In addition, under certain select circumstances, the court may subpoena treatment records. Washington court law indicates that you may also be waiving certain rights of privilege if you make your therapeutic relationship part of a court proceeding.

Please ask me to explain these circumstances. If your insurance is providing any reimbursement for Mental Health Services, they may also require a diagnosis and may ask for periodic reports of your treatment. Any release of confidential information will be discussed with you. Though the office is comprised of individual practitioners, there is a central waiting area. Your personal file is kept secure and managed only by myself. Should I not be reachable in an emergency, the therapist available may ask that you identify yourself. Seriously delinquent accounts with no provision for payment may be turned over for collections.

● EMERGENCY CALLS:

An answering service takes all calls. The service will attempt to locate me in the event of an emergency. Should I not be available and you want to talk with a therapist, the answering service will attempt to locate the therapist covering for me. **If you have an emergency, you should go the emergency room of SouthWest Washington Hospital.**

● TAPE RECORDINGS:

At some time during treatment I may wish to record your session for your benefit or for supervision or training. This will not be done without your consent.

● PROFESSIONAL CONSULTATIONS:

In order to provide quality care, it is sometimes necessary for me to request consultations from other professionals. I try to maintain good working relationships with various specialists in the areas of medicine, law, schools, etc. Psychiatric consultations will be requested for patients who might benefit from medication. Information regarding your professional contacts with this office will be released only if I have a signed statement of authorization from you. I encourage you to inform your family physician that you are in therapy.

● WHO I AM:

I am a separate, independent practitioner, sharing resources. I am compensated through separate, independent arrangements with my patients. I am a Licensed Psychologist (# 760) in Washington State. I will provide you with additional information about my training and experience.

● THE PRACTICE OF PSYCHOLOGY:

At your first appointment, I will discuss my philosophy, type of treatment, and qualifications. During the first few sessions, you will be informed of the specific type of treatment you will receive and an estimate of the length of your treatment. You are encouraged to address your questions or concerns about your treatment or therapist to me. You have a right to discontinue therapy or request a different therapist provided you have not been mandated to therapy by an agency. If you are mandated to treatment, the agency would also be involved in such a decision. Should you choose to do so, you are requested to discuss your decisions in the therapy session. Termination of therapy can also occur at my request. Possible termination reasons might include my no longer being able to assist you or that you are no longer able to assume your financial obligations of treatment. If you believe you have been treated unprofessionally or unethically, you can contact the ethics committee of the Washington State Psychological Association at (360) 363-9772 or the State Examining Board of Psychology at (360) 753-1392.

● *I UNDERSTAND, AND BY PARTICIPATION IN THERAPY, I AGREE TO THE AFORESTATED POLICIES AND PROCEDURES.*

Signature ____________________ Date __________

Parent, Guardian, or Second Signature ____________________ Date __________
(INDICATE WHICH BY CIRCLING THE APPROPRIATE DESCRIPTION)

Therapist ____________________ Date __________

KENNETH A. SHULTZ, ED.D.,P.S.

Licensed Psychologist (Washington # 760)

Diplomate, American Board of Medical Psychotherapists

APA Certificate of Proficiency in the Treatment of Substance and Alcohol Abuse

BACKGROUND AND TRAINING

I bring over thirty six years of mental health experience to my practice. Having received my Master of Science Degree and Doctorate from the University of Southern California, I completed Post-Doctoral Training at the Acute Psychiatric Unit of the Central City Mental Health Center in Los Angeles. I was then the Clinical Director for the Tarzana Psychiatric Hospital. I have over fifteen years of experience in both the residential and outpatient treatment of Alcoholism and substance abuse. Much of this has included the clinical administration of several agencies.

I have been a probation officer for Los Angeles County and also have eight years of teaching experience at both community colleges and at the University of Southern California. My background as a consultant has been extensive, including being a consultant to the Oregon State Department of Mental Health and designing Community Support System plans for several Washington counties. I have also trained staff for several hot-lines and the Los Angeles County Probation Department.

I was a member of the Washington State Advisory Subcommittee on Substance Abuse Treatment Standards and was the Staff Psychologist for the Monticello Medical Center Care Unit Alcoholism Treatment Program from 1980 to 1981.

I have been in private practice since 1969 and am a Washington State Licensed Psychologist, currently in full time private practice.

I am a member of the American Psychological Association and the Washington State Psychological Association as well as a Diplomate of the American Board of Medical Psychotherapists. I hold the APA Certificate of Proficiency in the Treatment of Substance and Alcohol Abuse

STATEMENT OF SCOPE OF PRACTICE

I typically present myself as an eclectic therapist. I have a strong background in cognitive and behavior therapy, physiology, object relations theory, family systems, substance abuse treatment, and humanistic psychology. I have had extensive training (including my Dissertation) in the use of group therapy with a variety of diagnostic constellations. My practice tends to be a mixture of short and long term clinical work. Although I do some evaluations, and consider myself an excellent diagnostician, I much prefer direct treatment and clinical supervision.

I have worked extensively with substance abuse and other compulsive and addictive disorders (both the dependent and co-dependent). I work with anxiety and depressive disorders, as well as personality disorders. I have substantial expertise in the treatment of Borderline, Narcissistic and other personality disorders, and these classifications comprise the bulk of my longer-term patients. I work with younger children and adolescents. I have worked with a large number of adolescents and families, and do play therapy when appropriate.

From a symptom perspective, I treat a variety of syndromes, including substance abuse (particularly dual diagnosis), weight loss, eating disorders, depression, panic disorders, some cases of sexual dysfunction, marital dysfunction, post traumatic stress disorder, grief, industrial injury, pain management, post surgical and/or cardiac recovery, attention deficit disorders, suicidal ideation/acting out, and adjustment disorders. My practice is composed of adults, families, adolescents, and children. Most recently I have been involved in training in the developing new field of Interpersonal Neurobiology.

REV: 04/08

I have obtained advanced training in the use of EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMD/R). EMD/R is a new procedure that has been shown to be very effective in the treatment of the anxiety and other symptoms associated with trauma. This procedure is effective in treating current trauma such as auto accident, death of a family member, or rape, as well as historic trauma such as child abuse, sexual abuse and other childhood trauma. Adults, adolescents and children respond well to this treatment.

INTAKE EVALUATION

Part I To be completed by parent

1. IDENTIFYING INFORMATION

Child's Name: ____________________ Today's Date: ________

Gender: M ___ F ___Age: _____ Birth Date: __________ Social Security (ID) Number: __________

Custodial Parent(s) Name: ____________________

Home Address: ____________________ City, State, Zip: __________

Telephone(s): __________ __________ __________

(home) mother (work) father (work)

May we leave messages for you at home? Yes or No: _____ May we leave messages at work? Yes or No:_____

Grade in School: _______ School: ____________________ Phone: __________

Referred by: ____________________

Others living in the home:____________________, ____________________

(name, birthdate, relationship to client) (name, birthdate, relationship to client)

__________, __________, __________

(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client)

Immediate family living outside the home: __________, __________

(name, birthdate, relationship to client) (name, birthdate, relationship to client)

Emergency contact: ____________________ Phone: __________

Insurance Information

Name of insured: ____________________ Insured date of birth: __________

Address of insured person: ____________________ City, State, Zip: __________

Relationship of client to insured person: __________

Insurance company: ____________________ Phone: __________

Insurance company address: ____________________ City, State, Zip: __________

Insurance identification number: ____________________ Group number: __________

Employer of insured person: ____________________

Secondary insurance: ____________________ Phone: __________

Name of secondary insured: ____________________ Date of birth: __________

Secondary company address: ____________________ City, State,Zip:__________

Secondary identification number: ____________________ Group number: __________

Employer on secondary insurance: ____________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

____________________ Date: __________

Child's Name: ______________________________

2. PRESENTING PROBLEM

Describe the child's problem(s) that brought you here today:

Check any of the symptoms that the child has been having:				This space reserved for additional comments by clinician:
Depressed mood		Feels hopeless		
Extreme sadness		Tearful/crying spells		
Trouble concentrating		Memory problems		
Change in sleeping habits		Lack of energy		
Security blanket or object		Stuttering		
Bedwetting		Thumbsucking		
Change in eating habits		Weight/appetite changes		
Problems getting along with family		Problems getting along with friends		
Doesn't seem to enjoy usual activities		Feeling of extreme happiness		
Trouble doing school work		Truancy		
Feeling stressed		Irritability		
Low self-esteem		Isolation/withdrawl		
Perfectionistic		Expresses feelings of guilt		
Worries		Seems nervous		
Feeling fearful		Sudden feelings of panic		
Phsysical complaints of pain		Tense/uptight		
Anger outbursts		Acting violently		
Running away		Harm to animals		
Has hurt or cut on themself		Firesetting		
Thoughts of killing self		Thoughts of killing others		

Continue on other side

3. WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

Have you worked with the child's teacher or school counselor? **Yes** ☐ **No** ☐

If you have, please describe it below.

Name of teacher or counselor:	Date(s):

Has the child been in counseling before? **Yes** ☐ **No** ☐

If the child has been in counseling before, please describe it below, starting with the most recent first.

A When was the counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	

B When was the counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	

Has the child been prescribed any psychiatric medications? **Yes** ☐ **No** ☐

If yes, please describe:	Date(s):

4. SUBSTANCE USE HISTORY (If Applicable) **CHECK HERE IF N/A** ☐

Does the child use tobacco (any form)?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the child use alcohol?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the child use caffeine (any form, including cola drinks)?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the child use recreational drugs?	Current ☐	Suspected ☐	Past ☐	No ☐

Continue on next page

Child's Name: ______________________________

5. MEDICAL INFORMATION

Has the child seen a doctor within the last year?	Yes ☐ No ☐
What was that for?	
Who is the child's doctor? Phone:	
Is the child taking any medications, prescription or over-the-counter?	Yes ☐ No ☐
Please list any medications that the child is taking:	
Please list any major medical problems that the child has had such as chronic illness, serious illness, operations, injuries or trauma to the head, etc.:	
Does the child have allergies to anything?	Yes ☐ No ☐
Describe any allergy problems that he or she may have:	
Does the child have problems with sleeping?	Yes ☐ No ☐
Does the child have problems with eating?	Yes ☐ No ☐
Does the child have problems with toileting?	Yes ☐ No ☐
Describe the problem(s):	
Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual or emotional)? Yes ☐ No☐ Please describe the relevant issue(s):	

6. DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or the delivery of the child?	Yes ☐	No ☐
Any problems with eating, sleeping or crying spells (colic, nightmares, etc.)?	Yes ☐	No ☐
Did the child demonstrate any difficulties or delays in walking, talking, toilet training?	Yes ☐	No ☐
Have there been any family crisis such as marital separation or divorce?	Yes ☐	No ☐
Have there been any mental health problems in the family of origin?	Yes ☐	No ☐
Have there been any substance use or abuse issues in the family?	Yes ☐	No ☐
Briefly describe the child's relationship to parents:		
Briefly describe the child's relationship to siblings:		
Briefly describe the child's temperment:		

7. SCHOOL HISTORY

When did the child start school?		
Were there any problems when the child started school?	Yes ☐	No ☐
What problems have come up during the school years?		
What grades is the child getting?		
Describe any changes in the child's school performance:		
How does the child get along with his or her teachers?		
How does the child get along with his or her friends or peers in school?		
What are the child's favorite subjects or school activities?		
What subjects or activities does the child have problems with?		

ABOUT OUR MANAGED CARE CONTRACTS

Managed care involves cooperation between client, provider, and insurance company to provide services as efficiently as possible.

Your contract with your health insurance company states that your mental health coverage is limited to:

1. Services that are determined to be "medically necessary." Medically necessary may be defined as presentation of a covered DSM IV Axis I diagnosis (these are acute symptoms).

2. Conditions that are able to be treated by short-term, problem focused, goal oriented approaches whenever possible.

You and your therapist will need to discuss the nature of your problems and set a specific goal(s) for treatment that falls within these guidelines. Your insurance will then cover a limited number of office sessions required to work on your problem as intensely as possible with the focus of eliminating acute symptoms. We will work with you to accomplish the identified goals in a cost-effective manner.

Members of this practice have entered into an agreement with your insurance company to provide services within these conditions. This practice reviews cases for quality assurance. Your case may be reviewed by a utilization review/quality assurance group set up by the insurance company or members of this practice. We will maintain your confidentiality in this process.

Sometimes people enter therapy with a number of problems. Some problems may meet the conditions of your insurance coverage while others (e.g., individual growth, long-term personality issues, etc.) will not. Should you desire to continue treatment for these or other non-covered conditions, your therapist will discuss options with you.

After the completion of services here,. you may receive a brief questionnaire to help us evaluate the services provided. if you would prefer to not receive such a questionnaire, please let us know.

If you have any questions about your coverage, confidentiality, or any aspects of your treatment, please ask your therapist.

PLEASE SIGN TO SHOW THAT YOU HAVE READ AND UNDERSTAND THE EXTENT OF YOUR COVERAGE AND THAT YOUR CASE MAY BE DISCUSSED FOR UTILIZATION REVIEW / QUALITY ASSURANCE.

______________________________ Signature(s)

________________ Date

One Park Place

7600 NE 41st Street, Suite 310
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BEVERLEY ALLEN, M.D.
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WALTER SPAFFORD, LCSW
JAIME VAZQUEZ, M.D.

From I-5 (either direction) take the Orchards, SR 500 Exit (Exit 2). Go approximately 4 miles on SR 500 and take the Andresen Exit. Go LEFT (North) on Andresen. After going under the overpass **(see below)***

From I-205 coming from the SOUTH take EXIT 30 (Orchards, Vancouver, SR 500). **Bear LEFT** on the exit so you end up on SR 500, heading west **towards Vancouver**, not Orchards. After passing Vancouver Mall / Westfield Shoppingtown, take the Andresen Road exit; and turn right onto Andresen Road heading NORTH **(see below)**.*

From I-205 coming from the NORTH take Exit 30 (Orchards, Vancouver, SR 500). Bear RIGHT onto SR 500, heading west **towards Vancouver**.
After passing Vancouver Mall / Westfield Shoppingtown, take the Andresen Road exit; and turn right onto **Andresen Road** heading **NORTH (see below)**.*

***From Andresen Road,** turn RIGHT onto NE 40th Street, which is clearly marked with a traffic light (US Bank and Comcast Cable are on the corners). The road will curve and change into 72nd Avenue. Take the FIRST RIGHT onto NE 41st Street. We are in the fourth building on the left side. A marker at the street says "Park Place Corporate Center". The awning at the front entrance says "One Park Place" and "7600". We are on the third floor in Suite 310.

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Parking: Use any available space (except "disabled"). Several one-hour "Visitor" spaces are available in the front of the building. There is also plenty of parking on the top level of the parking structure immediately to the west, behind "Two Park Place" (Enter the lot on the west side of that building).