Clinical Services Agreement and Consent Form

Welcome. This document contains important information about my professional services and business policies. Details regarding the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations, are provided in a separate *Notice of Privacy Practices* (Georgia Notice Form 2015) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information.

Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. Please understand that not all of the services described in this document may apply to you and the services that I have agreed to provide to you/your family.

If you have any questions or concerns, please feel free to discuss them with me.

SERVICES OFFERED

I will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. My clinical services consist primarily of individual assessments (psychoeducational, psychological, and neuropsychological evaluations) and short-term consultations with individuals, parents/significant others, educators, teams and other organizations, and related professionals.

APPOINTMENTS

Except for rare emergencies, I will see you (or your child) at the time scheduled. I understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, I ask that you speak to me personally and give me as much notice as possible to cancel or reschedule. This will allow me to offer your time to another person.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Psychological services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide me with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Georgia and Federal law and my professional codes of conduct/ethics. These exceptions are discussed in detail in the separate HIPAA Georgia Notice Form 2015.

RECORDS. I will review all testing results with you, and offer you opportunities to review raw testing data with me. I will forward copies of any reports or written summaries to others only with specific, written consent from you, though I routinely send this information to referring physicians (unless you expressly ask me not to do so). Because of the proprietary nature of testing materials, I will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

ELECTRONIC AND SOCIAL MEDIA. During our initial phone conversation(s), I requested your permission to leave voice mail messages at the phone number(s) you provided to me, and to correspond by email. If you granted your consent, note that it can be revoked by you at any time. Note, too, that I take reasonable precautions to safeguard the confidentiality of my electronic records and communications, using a HIPAA compliant email service (Hushmail) and secure fax but I cannot guarantee it with absolute certainty. I do not communicate with clients via text messaging or accept requests for social media connections (e.g., LinkedIn, Facebook) for

privacy reasons. If you have any questions or concerns about the security of our electronic communication(s) or the transmission of confidential information by electronic means at any time, please share them with me.

WORK WITH MINOR CHILDREN

If a client is under eighteen (18) years of age, the law may provide parents with the right to examine the minor child's records. Privacy, however, is often crucial to successful progress in treatment and valid evaluation results. If, in the course of an evaluation or consultation, a minor child reveals to me information that he or she does not want shared with his or her parents or guardian, I usually do not reveal such information unless I believe that there is a high risk that the minor will seriously harm him/herself or others, and in which case I will notify him or her of my intent to notify his/her parents or legal guardian(s).

FEES

My hourly fee is $200 per hour for consultations, meetings, observations, brief psychotherapy, and concussion-related consultations and brief evaluations. I charge this same fee on a pro-rated basis for telephone calls longer than ten (10) minutes (typically not covered by insurance), travel time for out-of-office meetings, and time necessary for record reviews and report preparation outside of the context of a comprehensive evaluation. Fees for expert testimony are $350/hour. Payment in full or expected co-payment (if seen at the Glenridge office) is due at the end of each appointment. Time spent on document preparation outside of face-to-face appointments, other than comprehensive evaluation reports, is also billed at my standard hourly rate.

For comprehensive neuropsychological and psychoeducational evaluations (evaluations scheduled over multiple days), I charge a flat fee of $3200 unless alternate arrangements have been made, with some exceptions. An extensive amount of time is committed and required to provide this kind of service; therefore, I ask that this fee be paid prior to the conclusion of the testing sessions: $400 is due at the end of the initial interview, and half of the remaining balance is due at the beginning of the first testing session ($1400), with the remainder due prior to the end of the second testing session ($1400). This fee/evaluation typically includes a review of records that you provide to me, an initial interview with the referral source (usually a parent or guardian in the case of a minor child), two 3-4 hour testing sessions with your child, limited consultations with other professionals working with you or your child, scoring, preparation of one comprehensive written report, and a 90-minute feedback session and a follow-up phone call (of less than 30 minutes). When routine testing extends into multiple sessions (as is sometimes the case with very young children, for example), no additional fees will be billed. When additional follow-up services are requested subsequent to the evaluation, these additional services will be billed at my standard hourly rate. Examples of some of these circumstances are provided below.

Comprehensive neuropsychological evaluations that also involve more comprehensive social-emotional assessment (including projective testing), or evaluations involving highly complex histories with more extensive record reviews and/or testing sessions (such as Independent Educational Evaluations (IEE's) or re-evaluations of adults for high-stakes testing) are usually billed at a higher rate (up to $3600, usually $3400 if projective testing is added to a comprehensive neuropsychological evaluation) to account for the additional time involved. If we have discussed the need for more extensive time/testing, this information will be listed in the confirmation email and attached to this document when we meet for the initial interview.

If, during the initial interview, the decision is made not to proceed with an evaluation, only the fee for the interview will be charged.

Concomitantly, I do not charge the full fee for more limited evaluations, such as psychoeducational evaluations, concussion evaluations, baseline testing, admissions testing, less comprehensive evaluations of very young children, or other kinds of partial evaluations (for example, when re-evaluation with a selected number of measures is requested to evaluate intervention effectiveness, or when there is current, previous testing that I will review but will not repeat as part of my evaluation); unless we have agreed to a flat fee in advance, fees for these services are billed at my hourly rate.

Some clients request additional follow-up support, advocacy, or consultation after completion of an evaluation or other services, and/or repeated follow-up calls. These additional services as provided to your or other parties, as well as the time necessary to complete any additional documentation for you (such as additional reports, cover letters, evaluation summaries, or insurance documentation), will be charged at my hourly rate.

For any services provided, if you provide me with original copies of records that I have requested, rather than photocopies, and you want the original documents returned to you, you will be billed at my standard hourly rate for my time spent photocopying your records.

Also be advised that many insurance plans do not pay for psychological testing or significantly limit the amount of coverage they provide for this kind of service (or other services judged to be primarily educational in nature). Public school systems, however, administer individual evaluations to school-age children at no cost to you (as governed by local/state educational agency regulations). I am happy to discuss this with you, or to work with your local school in order to coordinate services.

All fees are due at the time of service and as specified elsewhere in this agreement. Your account will be assessed $50/check for returned or refused checks. A missed appointment fee of $125 will be assessed for appointments cancelled with less than 24 hours notice. Please note that most insurance companies will not reimburse you for missed appointments.

PREPARATION FOR TESTING

It is important that individuals be able to perform at their best during testing sessions. Please let me know *before you arrive* (and as soon as possible) if the individual to be tested is not feeling well (except in case of concussions, when symptoms are expected), or is taking any prescribed or over-the-counter medications that I have *not* been told of in advance. In such cases (including leaving necessary prescription eyeglasses at home), the testing session may need to be rescheduled. If we have agreed that the individual to be tested should take regularly prescribed medications prior to testing and they did not do so, we may need to reschedule that session, and you may be charged for a missed appointment if we are not able to complete testing that day as scheduled. Individuals to be tested should be well rested and should bring snacks for breaks during the testing session. Parents should plan to remain in the office during all appointments with their minor children unless other (previous) arrangements have been specifically discussed with me.

SHARING TESTING INFORMATION. Summaries of brief consultations are typically provided same-day, or within 24 hours with more complex histories or referral questions, if all requested records are provided. For comprehensive evaluations, I will review all testing results during our feedback session, and offer you opportunities to review raw testing data with me.

Because of the proprietary nature of testing materials, I will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law.

HEALTH CARE INSURANCE

I am not a member of any insurance panels for services provided at the Path Group office on Pharr Road, but you may be eligible for reimbursement from your insurance company for some services provided by me there. For these services for which I am considered an out-of-network provider, I will provide you with statements that you may submit to your insurance carrier. These statements will include the CPT (procedure) codes, diagnostic codes, and dates/hours of service. I can often give you an estimate of what these may be prior to testing if that is helpful in order to determine what your insurance company may cover. I will also complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of-network services, but *you may be charged for the time involved to complete these forms*.

I am pursuing provider status for services provided at PANDA Neurology offices, however. I will typically need 24-48 hours for my billing staff to obtain an estimate of your out-of-pocket costs, and we will file the paperwork with your insurer on your behalf. Note, however, that only brief consultation and evaluation services are provided at the PANDA Neurology (Glenridge Drive) location.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to my clients' *Clinical Record* and disclosures of protected health information. These rights include requesting that I amend the record; requesting restrictions on what information from the *Clinical Record* is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

CONTACTING ME

Given my many professional commitments, I am often not immediately available by telephone. If you need to leave me a message, I will make every effort to return your call promptly (within 1-2 business days). If you are difficult to reach, please leave some times when you will be available. Because of the short-term nature of the services I usually provide, I do not typically provide on-call coverage 24 hours per day, 7 days per week, exchange text messages with clients, or regularly check/respond to emails outside of standard business hours Monday through Friday. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

CONSENT

Your signature(s) on next page indicates:

- you have read the information in this document and agree to abide by its terms;
- you have received the HIPAA notice form described above;
- if I am providing a comprehensive evaluation, you have received and read the *Comprehensive Evaluation Supplemental Information*;
- you have made every reasonable effort to provide me with complete, true, and accurate information as requested, including but not limited to information regarding any/all previous testing and current/anticipated involvement in related litigation;
- you understand that false, inaccurate, or incomplete information may invalidate any services provided; and
- you are legally authorized to provide consent for the services requested. In cases of separation or divorce, consent by all parents/legal guardians (those with legal custody) may be required; if it is required by law, your signature indicates that you have provided me with the contact information for any other party(ies) required to provide consent, if you have not already obtained that signature for me.

For services for minor children: child's signature below indicates that you have discussed the anticipated services with him or her. I will also discuss with your child the services to be provided on the (first) day of service. A parent or legal guardian should accompany minor children to each appointment and remain in the office, unless alternate arrangements have been discussed with me in advance.

If any client is no longer a minor, but is dependent upon another party (such as parents/guardians) for payment of services, signatures of all involved parties will be required below (though a signed release of information will be required in order to exchange any additional information with parents if the child is no longer a minor).

_____ _____

Client or Child's name Date

_____ _____

Client or Parent/Guardian #1 name Parent/Guardian #2 name

_____ _____

Client or Parent/Guardian #1 signature Parent/Guardian #2 signature

CONSENT TO TESTING OR CONSULTATION FOR CHILDREN UNDER THE AGE OF 18

My parent(s) (or legal guardian(s)) have discussed with me the purpose of my testing or other work with Dr. Shapiro. I understand that Dr. Shapiro will be working with me in order to help me at home and/or at school.

I agree to answer Dr. Shapiro's questions honestly, but I do not have to answer all of her questions if I am not comfortable sharing certain information with her.

Dr. Shapiro has told me that my parents have agreed that she does not have to tell them everything that I say to her if there is anything that I would like to remain private, unless there is a high risk that I will seriously hurt myself or someone else, or someone has caused serious harm to me. In this particular case, Dr. Shapiro will tell me if the information must be shared with my parent(s) (or legal guardian(s)) or others.

_____ _____

Child's signature Date