|  |  |  |  |
| --- | --- | --- | --- |
|  | Child Intake Packet |  |  |
|  |  |  |
|  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  Client DOB |  | Client Legal Name (Preferred Name) |
|  Evaluation or Therapy  |  | In-Person or Telehealth |
|  Service Type (circle one)Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | (circle)School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parental/Guardian Information |
|  |
|  |  |  |  |  |
| Parent/Guardian #1 | Relationship to client | Phone (cell/home/work) |
|  |
| Street Address/Zip Code |
|  |  |  |  |  |
| E-mail |  | Best way to contact? |  | Can we leave a message at the number above? |
|  |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Parent/Guardian #2 | Relationship to client | Phone (cell/home/work) |
|  |
| Street Address/Zip Code (if different from above) |
|  |  |  |  |
| E-mail |  | Best way to contact? |  |

 |

**Additional Information:****Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Who may we thank for referring you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Reason for referral: (circle one) Evaluation / Therapy****Type of service: (circle one) In Person / Telehealth****Brief description of reason to be seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Billable Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Phone: (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*****Your signature below indicates that you have been provided with the following:******1. Alabama Notice Form (HIPAA)******2. Client Services Agreement******3. Fee Schedule*****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Signature of Client Date Signature of Billable Party Date****Description of Services Offered****Screening/Consultation for Cognitive or Emotional/Behavioral Concerns**Record review, Intake (initial interview), 1-2 screening measures, feedback session, and brief written summary of findings. If the screening indicates the need for a Cognitive Assessment, aBehavioral/Emotional Assessment or a Comprehensive Psychological Assessment, the screeningpayment will be applied and serve as the first payment for the Assessment.**Schools, colleges, universities, professional schools, and employment sites do not accept screenings for accommodation approval. A full Cognitive, Behavioral/Emotional, or Comprehensive Assessment is required**.**Psychological Assessment, Cognitive Focused** (ADHD/LD, Processing Disorders, Intellectual Disability)Record review, Intake (initial interview), behavior checklists, computer test, IQ, achievement, feedback session, and written report. The final report includes clinical recommendations regarding accommodations when appropriate. The final report is provided to resources such as schools, therapists, and physicians with appropriate consent.**Psychological Assessment, Behavioral/Emotional Focused (**Mood Disorders, and Behavior Disorders)Record review, extended clinical interview, behavior checklists, projective testing, feedback session, and written report. The final report includes clinical recommendations regarding accommodations when appropriate. The final report is provided to resources such as the physician, school, and therapist with appropriate consent.**Comprehensive Psychological Assessment*-*** (Cognitive, Behavioral, and Emotional):Record review, extended clinical interviews, behavior checklists, computer test, IQ,achievement, projective testing, feedback session, and a written report. The final report includes clinical recommendations with accommodations when appropriate. The final report is provided to resources such as physicians, schools, and therapists with appropriate consent. **Individual, Marital, and Family Psychotherapy:** Dr. Smith is not currently accepting new therapy clients. She will provide short-term therapy to an assessment client if indicated. Long-term therapy clients will be referred to colleagues in the community. All sessions are billed by the therapeutic hour. **Group Therapy** includes Intake, screening for group appropriateness, and subsequent group therapy sessions. All sessions are billed by the therapeutic hour. **Psychoeducational groups/workshops**vary throughout the year and include topics such as stress management, anger management, communication skills development, sleep hygiene, mindfulness, and parenting classes.. Fees vary based on workshop/group topic, number of participants, materials utilized, and the length of presentation.**Billing Information**Although she is an approved provider, Dr. Smith is **not in network** with any insurance plans. Your insurance providers will reimburse at the out-of-network amount once the deductible has been met. All clinical services qualify for flex spending. You will be provided a monthly superbill that you can submit for reimbursement. Please contact your insurance provider regarding what type of reimbursement you can expect to receive. Inform them that you or your child will be receiving *psychological treatment or a psychological evaluation* with a licensed psychologist.For Assessment, there are 2 payment options. You may pay for the Assessment in full at the Intake session and receive a 10% discount or you may pay the $1000.00 retainer at Intake and the account balance at the feedback session. For therapy payment is due in full at the time of the session. *Dr. Smith accepts cash, checks, credit/debit health spending account (HSA), cards, Venmo, and Zelle.*The prices listed in the fee schedule reflect standard assessments. Additional fees may apply if the assessment requires additional measures or time. Any additional fees will be discussed with the client before administration. **Fee Schedule**

|  |  |  |
| --- | --- | --- |
|    | **Age of client** | **Fee Estimates** |
| Screening/Consultation ($200/hour), Paid in full at time of session | All ages |  |
| Psychological Testing, Cognitive Focused(billed at $200/hour), $1000.00 retainer, due at Intake; retainer applies to clinical fees. | 2-56-1819 and older | $1,400$1,600$1800 |
| Psychological Testing Behavior/Emotional Focused (billed at $200/hour), $1000.00 retainer, due at Intake, retainer applies to clinical fees.  | Children 2-1819 and older | $1,200$1,400 |
| Comprehensive Psychological Assessment($200/hour), $1000.00 retainer, due at Intake; retainer applies to clinical fees. | 2-56-1819 and older | $1,800$2,000$2.200 |
| Dementia Assessment  ($200/hour) $1000.00 retainer, due at Intake, retainer applies to clinical fees. | All ages | $1.000-1.500 |
| Pre-surgery/Bariatric Assessment  - fee due in full at session | All ages | $700  |
| Individual/Marital/Family Therapy (50 minutes) | All ages | $185/hour |
| Group TherapyIntake and screening  1 hour ; group     session 1.5 hours) | All ages | Intake $185.00/hourGroup session-$60-$80/hour |
| Psychoeducational groups- varies | All ages | Varies |

**Insurance Reimbursement Form****For informational purposes for the client only****Dr. Smith is out of network****All assessments are considered “psychological testing.”**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Primary Policy Holder: ( self / spouse / child / other:\_\_\_\_\_\_\_\_\_ )Primary Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy or FECA Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurer’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Deductible; (out-of-network provider): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reimbursement rate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does your insurance offer a POS (Point-of-Service) option for services? ( yes / no / unsure) \*\**Common POS insurance policies include Tri-Care Prime and certain United Healthcare policies\*\** **Credit Card Authorization Form (optional)**Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. Credit Card Information Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder Name (as shown on card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date (mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security code (CVV): \_\_\_\_\_\_\_\_\_ Cardholder ZIP Code (from credit card billing address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ I authorize my cc information to be kept on file. ☐ I give permission for my card to be charged after each session for **standard fees**. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardholder Signature Date

|  |  |
| --- | --- |
|

|  |
| --- |
| **CLIENT SERVICES AGREEMENT**Welcome to the Psychological Assessment Center, LLC (PAC). This document contains important information about our professional services and business policies. It also contains summary information about 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. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) 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 PAC obtains your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at the next session. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on PAC unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. **PSYCHOLOGICAL SERVICES** Psychological evaluations and therapy are not easily described in general statements. They vary depending on the personalities of the psychologist and the client, and the problems you are experiencing. There are many different methods that your psychologist may use to deal with the problems that you hope to address. Psychological evaluations and therapy are not like other doctor visits. Instead, they call for a very active effort on your part. For them to be most successful, you will have to work on the things that are discussed both during our sessions and at home. Also, you will have to be honest about the subjects we talk about and put forth good effort on the tests you are asked to complete as part of your evaluation or therapy. Psychological evaluations and therapy involve a large commitment of time, money, and energy. Therapy and psychological evaluations can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Assessment often leads to a better understanding of yourself, your relationships, solutions to specific problems, and significant reduction of distress. However, there are no guarantees of what you will experience when you take part in therapy or a psychological evaluation. **MEETINGS** Your psychologist will normally conduct an assessment that will last from 4 to 6 sessions. Assessment sessions will be 50-110 minutes, and therapy generally 50 minutes. Once an appointment is scheduled, you will be expected to pay a one-hour no-show fee unless you provide 48 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.  **PROFESSIONAL FEES** See Fee Schedule. If you are involved in legal proceedings that require our participation, you will be expected to pay for all our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge 300 per hour for preparation, attendance, and travel time for any legal proceeding and for forensic evaluations. **CONTACTING YOUR PSYCHOLOGIST** Due to the work schedule of your psychologist, they are often not immediately available by telephone. When your psychologist is unavailable, the telephone is answered by an answering machine or by the office manager. Your psychologist will make every effort to return your call within two business days, except for weekends and holidays. If you are difficult to reach, please provide times when you will be available in your message. In emergencies, call 911 or proceed to the nearest emergency room. If your psychologist is unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary.  **LIMITS ON CONFIDENTIALITY** The law protects the privacy of all communications between a client and a psychologist. In most situations, PAC can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advanced consent. Your signature on this Agreement provides consent for those activities, as follows: * Your psychologist may occasionally find it helpful to consult other health and mental health professionals about a case unless you object beforehand. During a consultation, your psychologist will make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. If you don’t object, you will not be notified of these consultations unless you feel that it is important to your work together. Your psychologist will note all consultations in your Clinical Record (which is called “PHI” in my Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information).
* You should be aware that this is a group practice with other mental health professionals and that we employ administrative staff. In most cases, your psychologist needs to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training in protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
* PAC has contracts with Electronic Billing Companies. As required by HIPAA, PAC has a formal business associate contract with this/these business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
* Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
* If you threaten to harm yourself or others, your psychologist may be obligated to seek hospitalization for you, or to contact family members or others who can help provide protection.

 There are some situations where we are permitted or required to disclose information without either your consent or Authorization: * If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. PAC cannot provide any information without your (or your legal representative’s) written authorization or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
* If a government agency is requesting the information for health oversight activities, PAC is required to provide it.
* If you file a complaint or lawsuit against your psychologist, then your psychologist may disclose relevant information regarding your services to defend themselves.
* If you file a workers’ compensation claim, we may disclose information relevant to that claim to
* the client’s employer or the insurer.

There are some situations in which PAC is legally obligated to take actions that are believed to be necessary to attempt to protect others from harm, and some information about a client’s treatment may need to be revealed. These situations are unusual at PAC, but you must be aware of them. * If we know or suspect that a child under the age of 18 has been abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
* If we know that an elderly or disabled adult has been abused, neglected, exploited, or sexually or emotionally abused, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
* If we believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s), we may disclose that information, but only to those reasonably able to prevent or lessen the threat.

 If one of these situations arises, we will make every effort to fully discuss it with you before taking any action, and we will try to limit my disclosure to what is necessary. Although this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and your psychologist at PAC is not an attorney. In situations where specific advice is required, formal legal advice may be needed. **PROFESSIONAL RECORDS** You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that are received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. If you provide us with an appropriate written request, you have the right to examine and/or receive a copy of your records, except in unusual circumstances that involve danger to you or others. In those situations, you have a right to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with your psychologist or have them forwarded to another mental health professional so you can discuss the contents. In most situations, PAC is allowed to charge a copying fee of $25. The exceptions to this policy are contained in the attached Notice Form. If PAC refuses your request for access to your records, you have a right of review, which your psychologist will discuss with you upon request. In addition, your psychologist may also keep a set of Psychotherapy Notes. These notes are for their own use and are designed to assist them in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless it is determined that such disclosure would be reasonably likely to endanger your health. **CLIENT RIGHTS** HIPAA provides you with several rights regarding your Clinical Record and disclosures of protected health information. These rights include requesting that your psychologist amend your record; requesting restrictions on what information from your 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 policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your psychologist is happy to discuss any of these rights with you.  **MINORS & PARENTS** **Clients under 14 years of age are not emancipated, and their parents should be aware that the law may allow parents to examine their child’s treatment records unless it is decided that such access is likely to injure the child, or we agree otherwise. Because privacy in psychological services is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child’s records. If they agree, during treatment, we will provide them only with general information about the progress of the child’s treatment and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child’s treatment when it is complete. Any other communication will require the child’s Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of the concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to manage any objections he/she may have.** **BILLING AND PAYMENTS** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a client’s care is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim. **INSURANCE REIMBURSEMENT** A detailed statement of fees will be provided for clients’ submission to insurance companies for self-filing claims. Our services do qualify for flex spending. Please note that many insurance companies require certain personal and medical information from the client to completely process claims. Deductibles and reimbursements vary widely among insurance providers. In fact, many of the major insurance carriers contract out the behavioral health portion of claims, making it even more complicated to understand and difficult to predict. .**ALABAMA NOTICE FORM****Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**Psychological Assessment Center, LLC may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions: * “PHI” refers to information in your health record that could identify you.
* “Treatment, Payment and Health Care Operations”
	+ Treatment is when Psychological Assessment Center, LLC provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when Psychological Assessment Center, LLC consults with another health care provider, such as your family physician or another psychologist.
	+ Payment is when Psychological Assessment Center, LLC, obtains reimbursement for your healthcare. Examples of payment are when Psychological Assessment Center, LLC discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
	+ Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination.
* “Use” applies only to activities within Psychological Assessment Center, LLC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “Disclosure” applies to activities outside of Psychological Assessment Center, LLC such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**Psychological Assessment Center, LLC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission beyond the general consent that permits only specific disclosures. In those instances when Psychological Assessment Center, LLC is asked for information for purposes outside of treatment, payment or health care operations, Psychological Assessment Center, LLC, will obtain an authorization from you before releasing this information. Psychological Assessment Center, LLC will also need to obtain an authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes your therapist made about a conversation during a private, group, joint, or family counseling session, which your therapist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.**III. Uses and Disclosures with Neither Consent nor Authorization**Psychological Assessment Center, LLC may use or disclose PHI without your consent or authorization in the following circumstances: * Child Abuse – If Psychological Assessment Center, LLC is treating a child and the therapist knows or suspects that child to be a victim of child abuse or neglect, they are required to report the abuse or neglect to a duly constituted authority.
* Adult and Domestic Abuse – If Psychological Assessment Center, LLC has reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, the therapist must report this belief to the appropriate authorities.
* Health Oversight Activities – If the Alabama Board of Examiners in Psychology is investigating Psychological Assessment Center, LLC, then your therapist is required to disclose PHI upon receipt of a subpoena from the Board.
* Judicial and Administrative Proceedings – If you participate in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and will not be released information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
* Serious Threat to Health or Safety – Psychological Assessment Center, LLC may disclose PHI to the appropriate individuals if the therapist believes in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).
* Worker’s Compensation – Psychological Assessment Center, LLC may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs, established by law, which provide benefits for work-related injuries or illness without regard to fault.

**IV. Patient’s Rights and Psychologist’s Duties**Patient’s Rights:* Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, Psychological Assessment Center, LLC is not required to agree to a restriction you request.
* Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, Psychological Assessment Center, LLC will send your bills to another address.)
* Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in Psychological Assessment Center, mental health, and billing records used to make decisions about you for as long as the PHI is maintained in the record. Psychological Assessment Center, LLC may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless the therapist makes a clinical determination that access would be detrimental to your health. On your request, I will discuss with you the details of the request and the denial process.
* Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your psychologist may deny your request. On your request, your psychologist will discuss with you the details of the amendment process.
* Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. At your request, I will discuss with you the details of the accounting process.
* Right to a Paper Copy – You have the right to obtain a paper copy of the notice from your psychologist upon request, even if you have agreed to receive the notice electronically.

Psychologist’s Duties:* Psychological Assessment Center, LLC is required by law to maintain the privacy of protected health information regarding you and to provide you with notice of my legal duties and privacy practices with respect to PHI.
* Psychological Assessment Center, LLC reserves the right to change the privacy policies and practices described in this notice. Unless Psychological Assessment Center, LLC, notifies you of such changes, however, Psychological Assessment Center, LLC, is required to abide by the terms currently in effect.
* If Psychological Assessment Center, LLC revises their policies and procedures, they will notify you by mail.

**V. Complaints**If you are concerned that Psychological Assessment Center, LLC has violated your privacy rights, or you disagree with a decision your therapist has made about access to your records, you may contact Dr. Bridget Smith, Director, at 334-742-9102.You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.**VI. Effective Date, Restrictions, and Changes to Privacy Policy**This notice will go into effect on April 14, 2003. |

 |

 |  |