CLINICAL NEUROPSYCHOLOGY ASSOCIATES

1528 Walnut Street
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Philadelphia, Pennsylvania 19102

(215) 735-2505

Fax (215) 735-2504

John E. Gordon, PhD ♦+ (1984-2017)
David J. Massari, PhD ♦+ (Retired)
Edward A. Maitz, PhD ♦●*
Joely P. Esposito, PsyD♦
Alison Metzler, PsyD
Sarah Gulick, PsyD

Donna M. Salvucci, MEd (267-560-7645)

Licensed Psychologists
Diplomates in Clinical Neuropsychology ♦
Certified School Psychologists +
Certified Cognitive Rehabilitation Therapist *
Certified Biofeedback Therapist ●

Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I, _____, authorize Clinical Neuropsychology Associates and/or its administrative and clinical staff to release:

_____

This information should only be released to:

_____ _____

_____ _____

I am requesting Clinical Neuropsychology Associates to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.):

_____

This authorization shall remain in effect until _____ or earlier upon the receipt of written request from the patient:

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that Clinical Neuropsychology Associates has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Clinical Neuropsychology Associates generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

_____ _____ _____

Signature of Patient/Guardian Relationship to Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

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Client Email Informed Consent Form

1. Risk of using email
   The transmission of client email has a number of risks that clients should consider prior to the use of email. These include, but are not limited to, the following risks:
   a. Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Email senders can easily misaddress an email and send the information to an undesired recipient.
   c. Backup copies of emails may exist even after the sender and/or recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect emails sent through their company systems.
   e. Emails can be intercepted, altered, forwarded or used without authorization or detection.
   f. Email can be used as evidence in court.
   g. Email may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email
   Therapist/Clinical Neuropsychology Associates cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Therapist/Clinical Neuropsychology Associates is not liable for improper disclosure of confidential information that is not caused by therapist's/Clinical Neuropsychology Associate's intentional misconduct. Clients/Parents/Legal Guardians must acknowledge and consent to the following conditions:
   a. Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.
   b. Email should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   c. All email will be printed and filed into the client's medical record.
   d. Provider will not forward client's/parent's/legal guardian's identifiable emails without the client's/parent's/legal guardian's written consent, except as authorized by law.
   e. Clients/parents/legal guardians should not use email for communication of sensitive medical information.
   f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between my therapist/Clinical Neuropsychology Associates and me, and consent to the conditions and instructions outlined, as well as any other instructions that my therapist/Clinical Neuropsychology Associates may impose to communicate with me by email.

Client name: _____

Client signature: _____ Date: _____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature: _____ Date: _____

Provider name: _____

Provider signature: _____ Date: _____

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Clinical Neuropsychology Associates (CNA) as your healthcare provider. We are committed to providing you with the highest quality services. You should be aware that, as a patient, you may have certain financial responsibilities for the services we render even if you have insurance coverage. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies. We are here to help you. If you need help understanding any part of this notice, please ask us.

HEALTH INSURANCE COVERAGE: It is *your* responsibility to be aware of your insurance coverage(s), policy provisions, exclusions and limitations as well as authorization and referral requirements. This information is furnished by your health insurance carrier(s). We will attempt to verify your insurance coverage prior to your visit. However, the financial responsibility for services is yours if your coverage is not in effect or your insurance requirements are not met *at the time of your visit*. If you have had any changes in your health insurance coverage - even a small change in the co-payment amount, a new plan year or a change in the expiration date of the policy - you must notify us promptly. You should contact your insurance company with questions.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES: Even if you have health insurance, your insurance company may not pay all the charges. Co-insurance and co-payments are portions of your healthcare bill that your insurance plan makes you financially responsible for. These are determined by your specific health insurance plan. Information on your outstanding insurance deductible is often provided only after a bill is submitted to your insurance carrier. These amounts can change and determining what these amounts are is your responsibility. *Even if you have Medicare or employer-sponsored health insurance, you may still receive a bill for outstanding amounts once your claims have been processed. You are responsible for paying this bill on receipt and for letting us know if you have questions about it.*

AUTO INSURANCE/WORKERS' COMPENSATION: Billing and medical information, as required for claims payment, will be forwarded to your auto or workers' compensation carrier as appropriate. You will also be required to provide us with up-to-date information on your health insurance coverage even if you believe an auto or workers' compensation carrier should be responsible for paying for services. You may still be responsible for the bill in the event your auto or workers' compensation carrier denies your claims or does not pay their full bill within a reasonable period of time after receipt.

NON-COVERED SERVICES: All patients are responsible for unpaid or "non-covered" services if denied by their insurance carrier(s). You will also be responsible for service fees if your check is returned for non-payment by the bank.

INSURER REQUESTS FOR ADDITIONAL INFORMATION: You are responsible for promptly responding to any request from your insurer(s) for additional information, including information on other insurance coverages you may have. Failing to respond may result in claim denials by your insurance, leaving you responsible for the bill. This may include requesting and forwarding a letter from your auto insurer indicating that your auto insurance medical benefits have been exhausted. If you are unclear on how to respond to an insurer request, you should contact your insurance company directly.

I have read and understand this financial responsibility form. I understand it is my responsibility to provide CNA the information described above, and I understand I am financially responsible for services not paid by my insurer(s).

Patient Name (print):_____

Patient Signature: _____ Date:_____

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INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES (Neuropsychological Evaluation Services Only)

Prior to starting video-conferencing or telephone services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing or telephone sessions (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the telephone or video-conferencing platform selected for our virtual appointments, and the provider will explain how to use it.
- You need to use a webcam or smartphone during the appointment, if possible.
- It is important to be in a quiet, private space that is free of distractions during the appointment.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.

Psychologist/Provider Name: _____

Psychologist/Provider Signature: _____

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

If read to patient and patient gave verbal consent, psychologist/provider should sign here:

_____

Date: ____/____/____