## CLINICAL NEUROPSYCHOLOGY ASSOCIATES

1528 Walnut Street
Suite 1500
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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CLINICAL NEUROPSYCHOLOGY ASSOCIATES

PATIENT INFORMATION SHEET

Patient Name:_____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: H: _____ W: _____C: _____

DOB: _____ Marital Status: _____ SSN:_____

Auto: _____ WC: _____ Other: _____ DOI:_____

Primary Insurance: _____ Mental Health: _____

ID or Claim #: _____ Policy or Group #: _____

Number of Visits/Year: _____ Co-pay: _____

Address: _____

Insured's Name: _____Relation to Patient: _____

Insured's DOB: _____Insured's SSN: _____

Adjuster: _____Telephone:_____

Secondary Insurance: _____Mental Health: _____

ID or Claim #: _____Policy or Group #: _____

Number of Visits/Year: _____ Co-pay: _____

Address: _____

Insured's Name: _____Relation to Patient: _____

Insured's DOB: _____Insured's SSN: _____

Adjuster: _____Telephone:_____

Referral Source: _____

Diagnoses: _____

Attorney: _____

Address: _____

Telephone: _____ Fax: _____

Name of Therapist: _____ Location: PA _____ NJ _____

Emergency Contact Name: _____ Phone #: _____

I authorize the release of any medical or other information necessary to process this claim.

---

Signature of Patient or Authorized Person (Relationship) Date

I authorize the payment of the medical benefits to Clinical Neuropsychology Associates.

---

Signature of Patient or Authorized Person (Relationship) 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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# PATIENT NOTICE FORM

## Notice of Psychologists' 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

I 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose 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, and case management and care coordination.
- "*Use*" applies only to activities within my practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have 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, and the law provides the insurer the right to contest the claim under the policy.

## III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I am required by law to report this to the Pennsylvania Department of Public Welfare.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, 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:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, I must take reasonable measures

to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

- **Worker's Compensation:** If you file a worker's compensation claim, I will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

## 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 protected health information about you. However, I am 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. Upon your request, I 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 my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and 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. I may deny your request. On your request, I 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). On 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 me upon request.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at the beginning of our next treatment session.

## V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Joely Esposito.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Dr. Joely Esposito, 1528 Walnut Street, Suite 1500, Philadelphia, PA 19102; 215-735-2505.

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.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

## VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on _____

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or prior to your next treatment session.

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


## INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

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 sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session, if possible.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- 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.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- We are making every effort to confirm that the insurance company will reimburse telepsychology sessions in the same manner that regular sessions are reimbursed. We have been told that most insurers will cover the sessions and in many cases, health insurance carriers have waived the co-pays. If your carrier does not reimburse for these

sessions, you will not be billed directly, for the time being. However, if these services are needed for an extended period of time, then we will need to discuss another financial arrangement.

- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name: _____

Psychologist Signature: _____

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

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

_____

Date: _____/_____/_____

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# THERAPIST-PATIENT SERVICES AGREEMENT

Welcome to Clinical Neuropsychology Associates. This document (the Agreement) contains important information about our professional services. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient 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 I 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 I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. 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 me unless I have taken action in reliance on it; if there are obligations imposed on me 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

Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Therapy is not

like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Therapy can have 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. But there are no guarantees of what you will experience.

Cognitive rehabilitation is a neurocognitive treatment approach for people who have cognitive difficulties as a result of traumatic brain injury, stroke, brain tumors, or other neurological problems. Difficulties may include problems with attention/concentration, memory, language skills, reasoning and problem-solving, and other necessary skills to complete the activities of daily living. Cognitive rehabilitation is designed to help individuals learn new ways to compensate for their deficits (using compensatory strategies) or to restore specific abilities (through cognitive remediation). Cognitive rehabilitation strategies are tailored to meet the specific needs and responsibilities of the individual at home, work, or school.

Our first few sessions will involve an evaluation of your needs and treatment goals. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another professional for a second opinion.

**MEETINGS**

I normally conduct an evaluation that will last about two sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If treatment is begun, I will schedule one 50-minute session (one appointment hour of 50 minutes duration) one or two times per week at a time we agree on, although some sessions may

be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it if you break the appointment or cancel with less than 24 hours advance notice [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.**

**PROFESSIONAL FEES**

The fee for psychotherapy and for cognitive rehabilitation is $300.00 per session. Other services include report writing, telephone conversations lasting longer than 30 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, completion of forms, and the time spent performing any other service you may request of me. There may be fees associated with these activities which will be discussed with you in advance.

**CONTACTING ME**

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, it is unlikely that I will answer the phone when I am with a patient unless there is an emergency. When I am unavailable, my telephone is answered by an answering machine, voice mail, or by my secretary. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If we agree to communicate by email, I will make every effort to return your email within the same business day, with the exception of weekends and holidays.

**LIMITS ON CONFIDENTIALITY**

With the exception of some legal situations, the law protects the privacy of all communications between a patient and a psychologist/therapist. In most situations, I 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, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information

confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I 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 I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share your protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I also have contracts with subcontractors for typing and billing services. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I 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 a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am 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 the professional services I provided to you, such information may be protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or

contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child who I am evaluating or treating is an abused child, the law requires that I file a report with the appropriate government agency, usually the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.

- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may be required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, 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.

While 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 I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

**PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge.] In most circumstances, I am allowed to charge a copying fee, which is based on recommendations made by the Department of Health. The copying cost will be discussed with you at the time of your request. If I refuse your request for access to our records, you have a right of review (except for information has been supplied to me confidentially by others) which I will discuss with you upon request.

In addition, I also keep a set of Therapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Therapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Therapy Notes are kept separate from your Clinical Record. Your Therapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a

condition of coverage nor penalize you in any way for your refusal to provide it – this does not apply to Workers' Compensation or to Automobile Insurance.

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I 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 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.

**MINORS & PARENTS**

Patients under 18 years of age, who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is sometimes my 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, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I 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 I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

**BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

**INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your therapy.]

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will

provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

| | |
|---|---|
| Patient/recipient Signature | Date |

**CLINICAL NEUROPSYCHOLOGY ASSOCIATES**

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Certified School Psychologists +
Certified Cognitive Rehabilitation Therapist *
Certified Biofeedback Therapist ●

# TREATMENT CANCELLATION POLICY

Clinical Neuropsychology Associates makes every effort to meet the scheduling needs of our clients. It is important for you to keep your scheduled appointments to insure that we can provide you with the services we have greed upon as part of your treatment plan. However, in order to be respectful of clients' and therapists' time, we have instituted a cancellation policy.

If you are unable to keep you scheduled appointment, you must provide **24** hours notice. If you cancel with less than 24 hours notice, you will be charged a late cancellation/broken appointment fee of **$50.00**. Under certain circumstances, your insurance company may place limits on the amount of this fee. If this applies, you will be charged the appropriate fee (_____). This cancellation fee will be billed directly to you and will not be covered by your insurance carrier. Payment of the fee must be made on or before your next scheduled appointment.

If you would like a telephone call confirming your appointment in advance, please discuss this with your therapist.

Your signature below certifies that you have read and understand the cancellation policy, and you agree to follow it. You will be provided with a copy of this policy for your records.

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Therapist Date