ARIZONA NEUROPSYCHOLOGY CENTERS

# Policies & Statement of Informed Consent

*This document contains important information about Arizona Neuropsychological Centers LLC professional services and business policies as well as the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protection 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 we provide you with a Notice of Privacy Practices (NPP) for use and disclosure of PHI for treatment, payment, and health care operations. The NPP, which has been emailed to you for review, explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information by the end of this session. We can discuss any questions you may have about procedures at that time. Please read it carefully and ask questions. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. The revocation will be binding on us unless we have taken action in reliance on it; if there are any obligations imposed on us by your health insurer in order to process or substantiate claims under your policy; or if you have not satisfied any financial obligations you have incurred.*

| **Psychological Services & Fees** | |
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| Arizona Neuropsychology Centers, LLC. offers the following services: Neuropsychological Evaluation, Psychoeducational Evaluation, Gifted Evaluation, and Independent Educational Evaluation (obtained through school district). All evaluations include a clinical interview, testing session, and feedback session. Pricing is as follows: Neuropsychological ($3000.00), Psychoeducational ($2800.00), Gifted ($800.00), and Independent Educational Evaluation ($3000.00*)<br><br>**Additional fees may apply for IEE's, which are outlined in our pricing sheet for school districts.* | **Initial Here** |

| **Contacting Arizona Neuropsychology Centers** | |
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| In the event of an emergency please contact 911, the nearest emergency room, or the Maricopa Crisis Line 1-800-631-1314. We may be reached by phone at 480-297-4492 or via email at admin@azneurocenters.com. If we are not available at the time you call, please leave a message with detailed information and we will return your call by the end of the next business day. We will also return emails by the end of the next business day. If you are difficult to reach, please include in your message, the best times to reach you. | **Initial Here** |

| **Electronic Correspondence** | |
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| It is often helpful to correspond through email over the internet. Arizona Neuropsychology Centers uses secure email; however, confidentiality cannot be guaranteed with communicating electronically. If you would prefer that personal information, not be exchanged over email, we will work with you to ensure that all communications will be conducted through direct interactions (phone or in-person). By initialing you are permitting the exchange of confidential information over the internet and understand the limitations in confidentiality when doing so. | **Initial Here** |

## Limits of Confidentiality

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by the Health Insurance Portability Accountability Act (HIPAA). Your signature on this provides consent for those activities, as follows:

We may find it helpful to consult other medical and mental health professionals about a case. During a consultation, we do not reveal the identity of the patient. The other professionals are also legally bound to keep the patient information confidential. If you do not object, we will not tell you about these consultations unless we feel it is important to our work together. We will note all consultations in your Clinical Record (which is our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

You should be aware that we practice with other mental health providers and that we employ administrative staff. In most cases, we need to share 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 who has prior written authorization.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

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 the professional services we provide you, such information is protected by the psychologist patient privilege law. We cannot provide any information without you or your legal representative's written authorization, or court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves. There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations may include:
- If we have reason to believe that a minor who we have examined is or has been the victim of an injury, sexual abuse, neglect, or deprivation of necessary medical treatment, the law requires us to file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect, or financial exploitation, the law requires us to file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim including themselves, and we believe that the patient has the intent and ability to carry out such threat, we must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. 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 we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

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| **Record Keeping** | |
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| The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which your problem impacts 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 we receive 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. | _____ **Initial Here** |

| **Patient Rights** | |
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| 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 we 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 our 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. We are happy to discuss any of these rights with you. For those undergoing Independent Educational Evaluation's (IEE) through a school district; a copy of the report upon completion will be sent to the school per federal law. | _____ **Initial Here** |

| **Minors & Parents** | |
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| ANC provides testing, assessments, and counseling to minors defined to be individuals under the age of 18. If a parent/legal guardian is bringing the child in for services, the written consent of both parents or legal guardians is required except as otherwise determined by law. Additional documentation of guardianship might need to be provided in certain circumstances, such as divorce before treatment can begin. | _____ **Initial Here** |

| **Billing & Payment** | |
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| Upon scheduling your first appointment, you will be required to give your credit card information to pay the non-refundable scheduling fee of $100 and agree to authorize Arizona Neuropsychology Centers LLC to charge that card for your sessions in the event that another payment has not been made at the time of service, or in the event of late cancellation or missed session that was not canceled prior to 24-hour notice. Payment is due at the time of service. The scheduling fee will be credited to your balance. You have the option to pay in full on your first visit or pay half at your evaluation session and half upon completion of your feedback session. We do not currently contract with any insurance companies, and you are responsible for 100% of the total bill. If you wish to submit to your insurance provider, you will be responsible for pursuing reimbursement from them.<br><br>ANC will provide you with a receipt for services for your records and to submit to the insurance company if necessary. 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 data we release regarding a patient's treatment is his/her name, services provided, and the amount due. If initiated, all costs will be included in the claim and the responsibility of the patient. | _____ **Initial Here** |

| **Health and Safety** | |
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| We maintain stringent cleaning and sanitizing procedures throughout the day and between every client visit. Please cancel and reschedule your appointment at any time if you or the client have experienced illness such as fever, coughing, runny nose, vomiting, or diarrhea within the last 48 hours. Your well-being, along with the health and safety of our ANC clinicians and management, is our top priority. Thank you for working with us to maintain health and safety for all. | _____ **Initial Here** |

| **Doctoral Student Training Notice (Optional)** | |
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| Arizona Neuropsychology Centers, LLC is staffed by licensed psychologists, post-doctoral fellows, and doctoral practicum students. Dr. Mather and/or Dr. Volrich directly supervise all non-licensed professionals in the office. Doctoral students are involved with aspects of informational gathering, face-to-face testing, report writing, and patient feedback. As part of their competency examinations, we may request students to audiotape/videotape client intakes or therapy sessions for the purposes of education, supervision, and training. The content of the recordings is purely confidential, maintained in secure location, and only examined by clinical supervisors and students. If you sign below, you consent to doctoral interns' audio/video recording. This is optional and not required to conduct our evaluation. ***If you choose to decline, this will in no way impact the evaluation process.*** | _____ **Initial Here** |

| **Minor Photo Release (Optional)** | |
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| The parent or legal guardian grants Arizona Neuropsychology Centers, LLC permission to use the photographs described as a single headshot, for office use, restricted to patient identification on personal medical files, and/ or a photo with the office dog, Iggy. Furthermore, I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use. Only authorized employees of Arizona Neuropsychology Centers will be able to view the photo. By initialing, I give my permission for a photo of my child to be printed and sent to them via mail at a later date. This is optional and not required to conduct our evaluation. ***If you choose to decline, this in no way will impact the evaluation process.*** | _____ **Initial Here** |

**<u>Consent for Treatment & Acknowledgement of HIPAA Notice of Privacy Practices:</u>**

*By signing below, you are stating that:*

1. *You have read and understood this policy statement*
2. *You have had your questions answered to your satisfaction.*
3. *You accept, understand, and agree to abide by the contents and terms of this agreement.*
4. *You consent to the evaluation and understand you may withdrawal at any time.*
5. *You have received and reviewed the HIPAA notice from us.*
6. *You accept, understand, and agree to abide by the HIPAA NPP provided.*

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**Patient Name**

| _____ | _____ | _____ |
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| **Parent/Guardian Name (if patient is a minor)** | **Parent/Guardian Signature** | **Date** |
| _____ | _____ | _____ |
| **Parent/Guardian Name (if patient is a minor)** | **Parent/Guardian Signature** | **Date** |