

INFORMED CONSENT NOTICE AND FEE AND PAYMENT AGREEMENT

Before we begin psychological services together, there are some things that you ought to know about the process and about our office. Legally, this is called "Informed Consent". This information contained here will help you understand better what to expect and will explain some limitations about what we will be doing together.

A BRIEF HIPAA OVERVIEW:

The Health Insurance Portability and Accountability Act (HIPAA) is 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 we provide you with our privacy practices for use and disclosure of PHI for treatment, payment or health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information before this 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 us 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.

CONFIDENTIALITY

All of our work together, our conversations, your records and any information that you give us, is protected by legal privilege. This means that the law protects you from having information about you or your child given to anyone. Our office respects your privacy and we intend to honor your privilege. However, there are some exceptions to your privacy that you should understand.

LIMITS ON CONFIDENTIALITY

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

We 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 we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we 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 our 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 our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

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II. Uses and Disclosures Requiring Authorization

We 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 we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations (of PHI) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we 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

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

- **Child Abuse:** If we have cause to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners of Psychologists, Licensed Professional Counselors or Social Workers, they have the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved 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 we will not release information, without written authorization from you or your personal or 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:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker’s Compensation:** If you file a worker’s compensation claim, we may disclose records relating to your diagnosis and treatment to your employer’s insurance carrier.

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IV. Client's Rights and Psychologist's/Clinician's Duties

Client'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, we are 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 us. Upon your request, we 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 our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny access to PHI under circumstances, but in some cases you may have this decision reviewed. You may examine and/or receive a copy of your, or in the case of a minor, the minor client's Psychotherapy Notes unless we determine that release would be harmful to your or the minor's physical, mental or emotional health. On your request, we 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. We may deny your request. On your request, we 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, we 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 us upon request, even if you have agreed to receive the notice electronically.

Psychologist's or Clinician's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you in writing by mail.
- The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining your privacy will be carried out in accord with the rules and guidelines of HIPAA, the American Psychological Association and other professional organizations.
- Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.

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- Tests and test results will be kept in a locked, safe place either onsite for one year and/or at a secure offsite location for seven years.
- You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. 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 in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

IV. Complaints

If you are concerned that we have violated your rights, or you disagree with a decision we made about access to your records, you may contact the Privacy Officer for Premier Psychological Services in writing to: Privacy Officer 3730 Kirby Drive, Suite 800 Houston, TX 77098. You may also file a complaint to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, 1301 Young Street, Suite 1169 Dallas, TX 75202 or calling (214) 767-4056.

CONSENT TO TREATMENT

I, _____ hereby seek and consent to take part in the psychological treatment and authorize Premier Psychological Services to perform an initial interview, therapy and/or psychological testing on _____. (client's name)

I understand that services may include face-to-face contact interviewing and providing therapy and/or testing services with a follow-up appointment to receive the results of testing. Services may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate.

Additionally, I am aware that the practice of psychotherapy or counseling is not an exact science and that the predictions of the effects are not precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures by this office or treating therapist. Further, I understand that evaluation and treatment will involve discussion of personal events in my and/or my families own history which, at times, can be discomfoting and is at times very personal. I am aware that I may terminate my treatment at any time without consequence, but that I will remain responsible for payment for services that I have received.

A clinician has told me the risks and benefits of receiving these services and the risks and benefits of not receiving these services for myself, and/or for this minor and his or her family.

MISSED APPOINTMENT POLICY

The policy concerning missed appointments has been explained to me. I understand that if I miss a confirmed appointment and do not call to reschedule within 7 days, this office will accept this as your notice that you have terminated this agreement and that you wish to discontinue services with our office. I understand that I may be charged for my missed appointment equal to the fee of the appointment. Additionally, I understand that if I miss my confirmed initial clinical interview, I may possibly not be allowed to reschedule this appointment due to our long waiting list of families needing to be seen. I also understand after two late cancelled or missed appointments, I may be referred out to another clinic. I also understand that if I do not return the front office's confirmation call by 3 p.m. the day before my

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appointment that my appointment may be filled with another waiting family. Additionally, if I no-show a multi-hour testing appointment, I understand that it may not be re-scheduled.

EMAIL CORRESPONDENCE*

The internet is not a totally secure medium for purposes of transmitting clinician-client or other privileged information. Professional advice will not normally be provided via internet. Any inquiry or contact with our website or office via the internet should not be considered a substitute for telephonic, written, or in-person communication. If you send messages by email or other electronic form of transmission, you acknowledge and agree that you may be compromising confidentiality by using such means of communication. If you do correspond with us by email, this indicates your consent to receive emails back from PPS and hold PPS harmless.

FEES AND PAYMENTS

The client assumes 100% responsibility for all services, including any and all balances from pre-approved out of network insurance coverage. I understand that the fee for this (these) service(s) will be \$225 for the initial clinical interview and \$175 per hour for subsequent scheduled therapy appointments. Full testing is charged at \$175 per hour, which includes time administering, scoring, record reviewing, consulting and report writing. Total testing costs can vary. Please discuss with our office for additional information regarding the total costs of our evaluations. NOTE: Our private school entrance exam fee (for only the WPPSI-IV or WISC-V) is \$275. Payment in full is due at the time of services.

The rate of out of network insurance reimbursement varies according to individual insurance contracts and I understand that I may be reimbursed based on my own health plan benefits and that I can request a "superbill" (a more detailed invoice) from PPS so that I may submit bills to my insurance company for said benefits. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for full payment for these services. I also understand that once services have been provided, (initial interview, testing, therapy, and other requested services) no refunds (credit card or checks) will be issued. Additionally, I am aware that missed appointments may be subject to a charge equal to the fee of the therapy appointment.

Occasionally, clients receiving services will request that the psychologist respond to emails/calls, review letters/records, write letters, call attorneys and other professionals. If these requests and similar requests become time consuming, we will collect payment of \$175/hr pro-rated or an administrative retainer of \$500. Additionally, if we are asked to make copies of sizable quantity of records, there may be a fee of \$1 per page and \$30/hour to copy the records. Additional hourly fees (\$175/hr) may apply for record review prior to copying records. Shipping charges, if applicable, will be included in the fee. We ask that you provide us with copies of pertinent records, not the originals.

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

Client's Printed Name

Client's Date of Birth

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Signature of client (or parent/guardian if client is a minor)

Date

*Email address you authorize PPS to use for correspondence (**please print neatly**)

I, the psychologist or clinician, have discussed the issues above with the client or with the minor client's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent of said client or of the minor client's treatment.

Signature of Psychologist or Clinician

Date

_____ Original to client's chart

_____ Copy of HIPAA document to client or guardian