Pediatric Neuropsychological Services of Alaska, PC

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NEUROPSYCHOLOGIST-PATIENT SERVICES AGREEMENT

Welcome to our practice. This document (the Agreement) 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 new 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 (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 we obtain your signature acknowledging that we 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 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.

NEUROPSYCHOLOGICAL ASSESSMENT SERVICES

What is a neuropsychological assessment?

A neuropsychological assessment is a means of determining a child's overall thinking, memory, attention and output abilities. It provides information on how a child's brain works. It involves a detailed analysis of the child's behavior in different settings and the administration of a variety of psychological tasks. The clinician uses these to evaluate general cognitive ability, communicative and language skills, visuospatial processing, executive (thinking, reasoning) skills, learning and memory abilities, attentional capacities, sensory and motor skills, social cognition, emotional adjustment, and academic achievement. Which specific tasks are chosen depends on [1] the referral questions, [2] the child's age, and [3] the availability of previous evaluations.

What is involved in a neuropsychological assessment?

At our clinic, neuropsychological assessment typically involves **one full day** evaluation session followed by a feedback or informing conference. An additional evaluation session may be needed if a child is very young, needs time to become familiar with what is required, or has limited stamina secondary to a medical condition. The feedback discussion is an integral and very important component of the overall assessment.

How much time do assessments take?

The evaluation session can take from 4 to 7 hours. They may be shorter for a young child or one who gets tired quickly. They may be longer if the child needs extra time to work - and is not too tired or overwhelmed to do so. Typically a feedback session will occur for parents/guardians to discuss the findings in detail and in order to provide a comprehensive plan for the child. Both parents are expected to attend the feedback session. Depending on the age of the child, s/he may wish to attend also.

Who should be present at the sessions?

Only one parent or caretaker need attend the initial evaluation sessions with the child, although all those involved with the child are welcome. We do not typically invite non-family professionals to the first feedback discussion - to allow private concerns to be discussed where necessary. We are available to meet at an additional session, to conference on the telephone, and/or to attend school meetings as necessary. (Attendance at school meetings must be agreed on in advance and requires a written contract for reimbursement.)

As a general rule, we expect that an adolescent who is competent to understand the discussion will attend the feedback discussion. Pre-adolescents are invited to attend, but may not wish to and should not be pushed to do so. Children younger than about 8 to 9 years are not typically interested in sitting around while they are discussed by adults. Whether or not a child should be invited/encouraged to attend can be discussed with the neuropsychologist at the end of the evaluation sessions if parents are unsure as to the value of having the child present.

How will I find out about the results?

You will meet with the neuropsychologist immediately after the testing session in which the findings of the evaluation will be discussed with you in detail. This will be followed by a written report that presents the child's history, behavioral observations, test findings, diagnostic formulation, management plan, and recommendations.

Who will get a copy of the report?

One copy of the report will be sent to you, one will be placed in your child's Medical Record, one will be forwarded to the referring physician, with your written permission.

If you wish, we will provide you with copies of the report for your child's school team, pediatrician/ primary care provider, psychotherapist, etc. You will then be able to distribute the copies of the report to the relevant professionals. No copies of the report will be distributed to anyone without your express written permission.

You should know that, if the assessment is paid for by your child's school, you have contracted to provide them with a copy of the report. We will still need your written permission to forward a copy to them - or you can provide them with a copy yourself.

PROFESSIONAL FEES

Our fee for neuropsychological assessment is between typically $5760.00 for children 6 years old and older. For younger children, the fee is reduced because it takes less time for testing and report writing. For other less comprehensive assessments, an estimate can be given prior to the assessment.

We charge an hourly fee of $480.00 for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of 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 $480.00 per hour for preparation and attendance at any legal proceeding. Depending on the circumstances, a minimum of 4 hours will be billed to you.

After we contact your insurance company, you will be informed of what fees will and what fees will not be covered and you are expected to pay your portion of the evaluation at the time of testing.

If you do not present for the testing session (No-show), you will be responsible for paying for the time the neuropsychologist has set aside for you (if however, he is able to fill this time, you won't be charged). In addition, we will NOT reschedule any appointments until your bill has been paid or alternative resolution has been agreed upon.

For cancellations, we ask that you provide 48 hours advance notice. If you cancel in less than 48 hours from the testing appointment, you may incur costs if we cannot schedule another patient. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

CONTACTING US

Due to our work schedule, we are often not immediately available by telephone. We will not answer the phone when we are with a patient. When we are unavailable, our telephone is answered by an answering service that is monitor frequently. We 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 us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call.

LIMITS ON 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 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:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We 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 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 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.

- 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.

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-patient privilege law. We 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 me to disclose information.

- If a government agency is requesting the information for health oversight activities, we are 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 are unusual in my practice.

- If we have reasonable cause to suspect that a child has suffered harm as a result of child abuse or neglect, the law requires that we file a report with the appropriate governmental agency, usually the Alaska Department of Health and Social Services. Once such a report is filed, we may be required to provide additional information.

- If we have reasonable cause to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect; or that a disabled person has been abused, the law requires that we file a report with the Alaska Department of Administration. Once such a report is filed, we may be required to provide additional information.

- If a patient communicates an immediate threat of serious physical harm to an identifiable victim, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will try to limit our 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 we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that we keep Protected Health Information about your or your child in your/their Clinical Record. If you provide us with an appropriate written request, you have the right to examine and/or receive a copy of your (child's) records. 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. We are sometimes willing to conduct this review meeting without charge. In most situations, we are allowed to charge a copying fee of $1.00 per page (and for certain other expenses).

Except in rare circumstances, you may examine and/or receive a copy of your entire record, if you request it in writing. In most situations, we are allowed to charge a

copying fee of $1.00 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form.

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 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.

MINORS & PARENTS

Since this is a pediatric practice, it is important for patients under 18 years of age who are not emancipated and their parents to be aware that the law allows parents to examine their child's treatment records unless we decide that such access is likely to injure the child or we agree otherwise.

BILLING AND PAYMENTS

You are expected to pay your portion of the assessment on the day of testing. We will bill your insurance for the assessment as well.

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, we have the option of using a collections agency and/or 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 patient/guardian's treatment is his/her name, the nature of services provided, and the amount due. If collections or litigation becomes necessary, patient/guardian will be responsible for all collection agency fees and reasonable attorney and court costs. In addition, a 10% interest fee will be added to the original cost.

INSURANCE REIMBURSEMENT

At this time, we are 'in network' providers for Primera Blue Cross/Blue Shield of Alaska. With this insurance or others, we will help you obtain pre-authorization for the assessment and once authorized, we will bill them directly for services. Depending on your plan, you may be responsible paying deductibles, co-payments, or coinsurance.

WE DO NOT ACCEPT TRI-CARE INSURANCE.

You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to your child. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of

your entire Clinical Record. In such situations, we 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, we 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. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

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.

_____

Print Name

_____ _____

Signature Date

TRICARE DENIAL FORM

I am seeking medical care from **Pediatric Neuropsychological Services of Alaska, PC.**

I understand that by signing this form, I am denying that I have **Tricare** coverage.

I understand that I am financially responsible for this account and that I am expected to pay in full at the time services are rendered unless other arrangements have been agreed upon.

Date: _____

Signature: _____

Printed Name: _____

Please read and sign this section only if we will be filing insurance for you (other than Tri-Care):

I authorize *Pediatric Neuropsychological Services of Alaska, PC* to supply my insurance company(s) with the information necessary to authorize services and to process insurance claims for me and /or my dependants. I also authorize payment of medical benefits directly to *Pediatric Neuropsychological Services of Alaska, PC* for the services provided.

_____
Print Name

_____ _____
Signature Date

PAYMENT FOR NEUROPSYCHOLOGICAL SERVICES PROVIDED WITHOUT AUTHORIZATION FROM INSURANCE COMPANY OR SCHOOL SYSTEM

SELF-PAY AGREEMENT

Most insurance companies, managed care plans, or school systems required the approval be obtained in advance for a neuropsychological assessment to be covered. You should be aware that *Pediatric Neuropsychological Services of Alaska, PC* has not received from your insurance company or school system a prior authorization for this assessment.

Your signature below indicates that you understand that you chose to receive a neuropsychological assessment that has not been authorized by your health plan or school system. By signing, you assume financial responsibility for paying all charges associated with this assessment.

I understand I will be responsible for all charges associated with my child's neuropsychological assessment at the *Pediatric Neuropsychological Services of Alaska, PC* clinic and agree to be so.

Signed: _____
Parent/legal guardian signature

Print name: _____

Date: _____

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