PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new 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 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 was provided separately, explains HIPAA and its application to your personal health information in greater detail. When you sign this document, it will also represent an agreement between us and your understanding of the limitations on confidentiality.

NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL TESTING

INFORMED CONSENT

Welcome. You have most likely come to my office because your child is experiencing problems requiring further assessment. Please take a moment to read this form and ask for additional information or clarification.

Nature of My Services. I am licensed and trained to practice psychology in the state of Texas. I have a doctorate degree in clinical psychology from the California School of Professional Psychology in San Diego and am board certified through the American Board of Pediatric Neuropsychology. I am also a member of the National Association of Neuropsychology, the International Neuropsychological Society, the Texas Psychological Association, and Society for Clinical Neuropsychology (Division 40 of the American Psychological Association). I have extensive training in conducting psychological, psychoeducational, and neuropsychological assessments.

Assessment. Neuropsychological and psychological assessment includes a comprehensive evaluation of your child's intellectual, academic, and/or emotional functioning. The evaluation will require direct contact, interviewing, and testing. I will also collect and review information from schools, psychologists, psychiatrists, and other professionals involved in your case.

Depending on the number of tests being administered, we will typically meet on three or four occasions for 1 ½ to 4 hours each session. An appointment is a commitment to our work. If you need to cancel an appointment, please give me at least 72 business hours notice by telephone (not email). I will make every effort to re-schedule your cancelled appointment. Cancelled appointments will delay our work together.

Fees. My testing fee includes time spent on the intake interview, test administration, scoring, interpretation, report writing, consultation with other professionals involved in the case, and feedback. We will work together to set up a payment schedule. You are fully responsible for payment for these services. The process will most likely take three to four weeks. By the end of our time together, you will have better understanding of you or your child's difficulties, and you will be provided with an extensive written report and recommendations. You will also have an opportunity to ask any questions regarding the testing or testing results. Please note that your child is welcome to attend the final feedback session, if appropriate. Alternatively, you may schedule an additional feedback session for him/her to discuss these results with me in a manner more suitable to his/her developmental level. This additional feedback session will be billed at my hourly rate.

According to law and ethics code, I have the right to turn over unpaid bills to a collection agency. If this should occur, I will provide you with the opportunity to pay and will notify you if I contact an agency. I will also charge in full for an appointment cancelled with less than 72 business hours notice (i.e. not weekend days or holidays). Cancellations must be made by telephone, not email.

INITIALS_____

Payments may be made by check, cash, or credit card. All checks should be made payable to Pediatric Neuropsychology Services. Returned checks are subject to a $25.00 service charge. Please note that I do not bill any insurance company directly. It is therefore customary to pay for all services at the time they are rendered. You will be provided with a bill at the end of each session to enable you to seek reimbursement from your insurance company. However, please recognize that when insurance companies are used, there may be limits to confidentiality. Usually, insurance companies ask for information about duration of illness, psychiatric diagnosis, dates of service, name of treatment provider, treatment goals, and the details of the treatment session. In addition, providers are now required to sign waivers that allow the company to audit patient records.

If I am subpoenaed or otherwise required to participate in a legal processing as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony. **This will be billed at twice my regular rate**.

Similarly, school observations or consultation out of the office is also billed at 1 ½ times my regular rate, including travel time.

Confidentiality. It is important for you to know about my confidentiality policy. Confidentiality is vital to treatment progress. In general, according to the law and my ethics code, what you and your child discuss with me is not shared with anyone else without your written permission. However, there are several exceptions, which are designed for your protection and safety. These exceptions include:

1) If you or your child is a victim of child abuse, or if you or your child divulges information about such abuse, I am required by law to report this to the appropriate authorities.
2) If you or your child is a victim or perpetrator of elder or dependent adult abuse, or if you or your child divulges information about such abuse, I am required by law to report this to Adult Protective Services or other appropriate authorities.
3) If you or your child threatens harm to yourself, someone else, or the property of others, I may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm.
4) If ordered by the court, I may have to testify or release your records.
5) I may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law I can not reveal when I have disclosed such information to the government.

I may also consult with another professional from time to time, but without identification of the patient whose case is the subject of consultation.

In the extremely unlikely event that I determine that I am not the right fit for your child or family, I reserve the right to make an appropriate referral.

Please also note that in the case of separation or divorce, I do not keep secrets from either parent and will need to share all information with both parents (assuming joint custody).

Emergency Procedures. If you need to contact Dr. Lurie, you may call (972) 248-3682 and leave a message. Dr. Lurie checks messages on a regular basis and your call will be returned as soon as possible. In a life threatening emergency, please call 911 or go to the nearest emergency room. You may also contact your community crisis hotline, e.g. Suicide & Crisis Center hotline (214) 828-1000.
I look forward to working closely with you.

I have read and understood the information and policies described in this form. I have also been given the opportunity to ask questions, and have had my questions answered. I hereby agree to this psychological evaluation with Dr. Michelle Lurie, and to cooperate to the best of my ability, as shown by my signature below.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____
(if applicable)