Delaware Psychological Services & Associates

Child Version:

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Delaware Psychological Services. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment
    f. The expectation that if prescribed medication, my child and/or I will participate in therapy.

    The evaluation or treatment will be conducted by a a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Delaware Law and accepted guidelines for Psychological, Psychiatric, Nursing, Social Work, and Professional Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at Delaware Psychological Services, and I consent to disclosure for use by Delaware Psychological Services clinicians for the purpose of continuity of my child's care. Per Delaware mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

7. **Hold Harmless:** I agree to indemnify and hold harmless Delaware Psychological Services or any agents thereof for any expense or claim of harm relative to my child's participation in school based or office based behavioral health treatment that may be a part of my child's Individual Education Plan (IEP) or 504 Plan.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of legal guardian for minor under age 18 **Date**

_____ _____

Signature of witness **Date**

You may file a complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated. We will provide you with a form for filing this complaint with us, and you will not be retaliated against for filing such a complaint. To file a complaint contact HIPAA Coordinator Delaware Health & Social Services/Division of Public Health, 417 Federal Street, Dover, DE 19901 (302) 744.4706 for further information and/or to request a "Violation of Privacy Rights Complaint Form."

ADDENDUM

- If there is a breach of your confidentiality, then we must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless we (the covered entity) can show that there was a low risk that the PHI has been compromised because the unauthorized person did not view the PHI or it was de-identified.
- If you are self-pay, then you may restrict the information sent to insurance companies.
- Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization.
- You must sign an authorization (release of information form) for releases unless it is for purposes already mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc.).
- You have a right to receive a copy of your Protected Health Information in an electronic format or (through a written authorization) designate a third party who may receive such information.

Delaware Psychological Services, LLC
17021 Old Orchard Rd.
Lewes, DE 19958

Patient's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Delaware Psychological Services Notice of Privacy Practices.

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: _____

Printed Name: _____

Date: _____

Delaware Psychological Services & Associates

Payment Agreement

Our Fees

- Initial Diagnostic Assessment & Evaluation: $135/hr for LPCMH or LCSW; $175/hr for Psychologist
- Individual Therapy: $135/hr for LPCMH or LCSW; $175/hr for Psychologist
- Couples or Family Therapy: $135/hr for LPCMH or LCSW; $175/hr for Psychologist
- Crisis Psychotherapy – complex or life threatening circumstances that require immediate attention; $135/hr for LPCMH or LCSW; $175/hr for Psychologist
- Group Session (60 Minutes): $35 per session
- Co-parenting Services: $135/hr for LPCMH or LCSW; $175/hr for Psychologist
  **Services are not billable or reimbursable by insurance companies
- Psychological Testing/ Assessment: $175/hr, but may vary dependent upon nature of test and extent of report writing. $150/hr for Report Writing
- Court related work including preparation of letters and evaluations, testimony; travel time, time away from office due to legal proceedings and review of records for legal purposes: $250 per hour.
- Educational Consultation : $175 per hour (30 minute minimum)
- Medication Evaluation: $250 per hour
- Medication Management: $150-$200 per 30 minutes
- Medication Management: $50-$75 per 15 minutes
- Telephone consultation and non-routine paperwork $30 for each 15 minute unit
- No-Show for Appointments or Late Cancel within 24 hours of scheduled apt: $50
- Records Request $60

Please note that billable time is calculated to the nearest 15 minute interval. For example, a session lasting 40 minutes will be billed as a 45 minute session and a session lasting 53 minutes will be billed as a 60 minute session.

Insurance Payment

If you are using your insurance to pay for services, it is your responsibility to be aware of your policy benefits and limitations. Please provide your insurance card at your initial appointment. **Payments are due at the beginning of each appointment.**

INSURANCE COMPANY: _____

Amount due each session: _____ Deductible: _____

It is your responsibility to be aware of your policy benefits, financial obligations, insurance limitations as well as to verify that we are in network with your insurance plan. Please note that if you have a deductible you will be responsible for paying 100% of your insurance company's allowable rate for the service until your deductible is met. Services provided in good faith will be billed directly to you if later determined that your policy has expired, lapsed or does not cover the service(s) provided. Please note that some insurance companies require pre-certification of services and may require personal information related to your diagnosis and treatment plan. Please refer to the "Notice of Privacy Practices" or "HIPPA Notice" for more specific information provided to you. You are entitled to receive a paper copy upon request.

If we do not accept your insurance, you will be responsible to pay our full fees as listed above. Upon request, you will be provided with a statement for any services rendered, which you may submit to your plan for reimbursement if your policy has "out of network" benefits.

Payment:

Payment is due at the beginning of each session unless other arrangements have been made. Payment options include cash, check, Visa, MasterCard and Discover. Please note that you will be responsible for any bank fees for returned checks.

If paying by check, please make checks payable to: "Delaware Psychological Services"

Missed Appointments:

Please make every effort to keep your scheduled appointments. You agree to accept financial responsibility for any missed appointments not cancelled within 24-hours of your scheduled appointment time. Following two missed appointments without cancellation a **missed appointment or late cancellation fee of $50 will be applied and is not billable to your insurance company.** In the event of continued missed appointments or cancellation, Delaware Psychological Services reserves the right to close your case and refer you for services to another provider.

Late Payment Fee:

A $10 late fee will be added to your account if payment is not received within 30 days upon receipt of a bill for your account.

Financial Hardship:

You agree to contact us to establish a payment plan if you are experiencing financial problems that make it difficult to pay your bill.

Non-payment:

Account statements shall be deemed to be accepted by you unless we are notified in writing within 14 days of the statement being issued that you dispute the charges. You also acknowledge that your account may be referred to a licensed collection agency if your account becomes 60 days past due. You will be notified of our intent to do so in advance and will be offered the opportunity to settle your account to avoid being sent to collections. By virtue of this agreement you are providing your consent to release your account balance and necessary contact information (name, address, date of birth, social security number) to a licensed collection agency in an effort to collect your debt. Please be aware that if your account continues to be unpaid, the licensed collection agency is authorized to report all outstanding debts to the four major national credit agencies.

Additional Cost of Collection Services:

In the event that your account is sent to collections, you will be charged legal and debt collection fees incurred by Delaware Psychological Services in relation to the recovery of outstanding debt, which is 100% of the balance due on your account.

Authorization for Insurance Billing/Assignment of Benefits

I authorize the release of information necessary to process insurance claims, and assign my benefits directly to Delaware Psychological Services.

Acknowledgement & Agreement

I have carefully read, understand and agree with all the terms of this agreement and agree to abide by its guidelines. I have had an opportunity to ask questions and I acknowledge that I may receive a copy of this agreement upon request.

_____ _____

Signature of Patient/ Responsible Party Date

Delaware Psychological Services & Associates

Authorization for Release of Information

I _____, born on _____, hereby authorize:

Delaware Psychological Services
17021 Old Orchard Rd.
Lewes, DE 19958
303-703-6332

To release and/or obtain, the following information in ☐ my records ☐ my child _____ records:
☐ Mental health and medical history, including diagnosis
☐ Records of outpatient treatment
☐ All diagnostic, psychological assessment
☐ Academic records including grades and standardized testing scores
☐ Other: _____

This information is to be ☐ released to ☐ obtained from:

_____

This information is to be released for the following purpose(s):
☐ Treatment planning & coordination of behavioral health services
☐ Third party billing
☐ At the request of the individual, parent or authorized agent
☐ Forensic Evaluation – I understand that my authorization to release the results of the evaluation may present favorable or unfavorable implications related to the assessment findings and/or recommendations. I have been informed of the risks pertinent to participation in a forensic evaluation during my initial appointment.
{Initials: _____}
☐ Other: _____

I understand that I have the right to revoke consent to future disclosure in writing at any time, however this revocation will not be effective to the extent that I have already taken action in reliance on this 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 my treatment generally may not be conditioned on signing a release of information, unless the services are provided to me for the purpose of providing information to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPPA privacy rule. I acknowledge that I have had the opportunity to discuss and ask questions about issues concerning privacy and confidentiality and this consent.

This is authorization will remain in effect until _____ unless otherwise revoked in writing at a future point in time.

_____ _____
Signature of Adult Client or Legal Guardian Date

_____ _____
Printed Name of Adult Client or Legal Guardian Signature of Minor (if applicable)

_____ _____
Signature of Witness Date

Delaware Psychological Services & Associates

Authorization for Release of Information

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Printed Name of Adult Client or Legal Guardian Signature of Minor (if applicable)

_____ _____
Signature of Witness Date

Delaware Psychological Services & Associates

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE ARE REQUIRED BY LAW TO PROVIDE YOU WITH THIS NOTICE. PLEASE REVIEW IT CAREFULLY.

In general, we may not use or disclose protected health information except:

- To you
- With your written consent to carry out treatment, payment or health care operations
- With your written consent in other circumstances when an authorization is required.

Psychotherapy notes may not be used or disclosed without your specific consent except

- For use by your therapist
- By us to defend a legal action or other proceeding brought by you.

Psychotherapy notes: "*Psychotherapy notes"* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date" (45 CFR § 164.501).

We are **required** to disclose protected health information **to you** when your request meets the requirements of a proper request, and to the Secretary of Health and Human Services when required to investigate or determine our compliance with these Regulations.

We must make reasonable efforts to limit the disclosure to the **minimum information necessary** to accomplish the purpose of the use, disclosure or request.

If State law or other applicable regulations are more stringent than these Regulations, we must follow the more stringent rules with regard to use and disclosure. If these Regulations are more stringent than State law(s), we must follow these Regulations.

You have the right to request restrictions on certain uses and disclosures of protected heath information. However, we are not required to agree to a restriction you request. If we agree to a restriction we must document this and abide by it unless the information is needed by another health care provider to provide you emergency treatment.

We may use or disclose your protected health information **without** your written consent or authorization or without providing an opportunity for you to agree or object

- For mandating reporting of child or elder abuse
- Reporting of impaired drivers
- To avert a serious threat to health or safety
- For worker's compensation and disability claims
- Other allowable circumstances (e.g., responding to a court order, etc.)

Delaware Psychological Services & Associates

You have the right to inspect and copy protected health information except:

- Psychotherapy notes
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding

In rare circumstances, we may deny you access to protected health information, for example

- If access is reasonably likely to endanger your life or physical safety or someone else's life or physical safety
- The information refers to another person and access requested is reasonably likely to cause substantial harm to that other person or
- If providing the information to your personal representative is reasonably likely to cause that person or another person substantial harm.
- In most cases when access is denied, you may request a review of the denial. If you request a review, the review will be completed by a licensed health care professional we have designated for this purpose and who did not participate in the original decision to deny access. We must abide by that person's determination.

Other uses and disclosures of your protected health information will be made only with your written authorization. You may revoke such authorization at any time provided you do this in writing and we have not already acted on your prior consent, or if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy.

Additional Rights & Information:

- You have the right to amend your protected health information.
- You have the right to receive an accounting of disclosures we make of your protected health information.
- You have the right to receive a paper copy of this Notice from us upon request. We must have this Notice available at our clinic for you to request to take with you. We must post this Notice in our clinic and on our web site if applicable.
- We are required to abide by the terms of this Notice currently in effect.
- We are required to provide this Notice to you no later than the first date we provide service(s) to you after these go into effect.
- In order to apply a change in a privacy practice described in this Notice, we will provide you with a Revised Notice at your next scheduled visit after the revision, by posting this to our web site, and by a paper copy upon your request.
- We must implement policies and procedures related to this Notice and the Privacy Regulations and maintain those policies and procedures in written or electronic form.

You may file a complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated. We will provide you with a form for filing this complaint with us, and you will not be retaliated against for filing such a complaint. To file a complaint contact HIPAA Coordinator Delaware Health & Social Services/Division
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Date: _____