Consent for Psychological Assessment of a Child

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask me to clarify anything that you do not understand. When you sign this document, it will represent an agreement between us.

I request that Dr. Lori Radner provide psychological testing and/or assessment services to _____for whom I am legal guardian. The evaluator is a fully licensed psychologist. Testing administration is conducted by a psychometrician, who are either at the Master's level or Doctoral level. This form is to document any consent for assessment and/or treatment as well as an agreement to the conditions of the assessment and/or treatment.

The assessment may consist of interviews with the parents, surveys, educational tests and/or psychological tests. Areas to be assessed may include intellectual and academic functioning, attention and concentration, psychological status and emotional state. I understand that the results from this assessment and the written report will not be shared with anyone unless I give permission for such a release of information.

Most children find psychological assessment to be an interesting experience as well as a means of learning more about themselves. It is generally thought of as a benign procedure, however sometimes people can be disappointed or unsettled by the results. In addition, any discussion of problems may bring about some emotional strain or distress. I am welcome and encouraged to discuss with the evaluator any and all questions or concerns that I have regarding the assessment. I understand that the practice of psychological services is not an exact science and so predictions of its benefits, outcomes or duration are not precise or guaranteed.

I agree to be financially responsible for the entire cost of the evaluation, minus any insurance coverage I may have. Checks should be made payable to Lori Radner. I understand that I will give a deposit of $500.00 at the first session of the testing evaluation if I do not have insurance coverage. Normally a regular evaluation takes anywhere from 12-15 hours and usually costs about $2700.00. This includes the time for testing, scoring, interpretation, report writing and feedback sessions. The full amount will be due upon receipt of the final report. I understand that I can suspend the evaluation at any time, but I will still be responsible for timely payment of those services rendered prior to the ending of the assessment. A $25.00 fee will be charged for no show appointments without 24-hour notice.

The evaluator does not perform forensic work. If circumstances are such that she has to get involved in a forensic issue, I will be responsible for paying for her professional time at $400.00 per hour and I will be responsible for paying for all of her legal fees. In addition, I understand that involving her in a legal situation may jeopardize the therapeutic relationship and confidentiality and the evaluator may choose to terminate and transfer me to another professional.

The evaluator checks his/her voicemail periodically during regular business hours on weekdays. That number is (248)-788-6400 Ext. 2. I understand that if at any time there is an urgent situation that cannot wait for a return call; I may contact Common Ground's 24-hour mental health crisis hotline at (248)-456-0909. If the situation is life threatening in nature, I know that I should go directly to the emergency room at the nearest hospital or dial "911"

I understand that conversations with the evaluator are confidential. No information will be released without my consent with the following exceptions. By law, the evaluator must report suspected child or elder abuse/neglect to the appropriate authorities. In addition, the evaluator has a legal duty to break confidentiality if a patient presents an imminent danger to self or to someone else. In case of emergency, information necessary to provide for the care of the patient may be disclosed. In addition, if electronic communication is utilized, I understand that there may be risks to confidentiality. Furthermore, the evaluator may confidentially consult with a supervisor or colleagues.

Telehealth Informed Consent Form Addendum

If telehealth services are being administered, I understand "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications

Lori Radner Psy.D. and staff utilize Doxy.me, which is a HIPAA-compliant telemedicine platform to protect the confidentiality of patient identification and any information transmitted during telepsychology sessions. There are potential risks associated with the use of telepsychology. These risks include rare cases where security protocols could fail, causing a breach of privacy of personal medical information. In addition, a potential risk may involve information transmitted being poor resolution, which may make the video portion of the visit of lesser quality

By signing this form, I also understand the following regarding telehealth:

I understand that the laws that protect privacy and the confidentiality of medical information mentioned above also apply to telepsychology.

I understand I have the right to withhold or withdraw my consent to the use of telepsychology in the course of care at any time, without affecting my right to future care or treatment.

I understand that a variety of alternative methods of psychological care may be available to me, and that I may choose one or more of these at any time. My psychologist may also determine that telepsychology is no longer appropriate/necessary and in person sessions should alternatively be resumed.

I understand that I must use a secure internet connect to maintain confidentiality optimally. The person providing the services will give directions on getting into the platform, how the session will work, etc. Any materials that are mailed to you, such as response booklets, should not be opened until the evaluation starts and should be

enclosed immediately after completed. I will not add or take away any responses by my child on these materials and I will not copy any of the materials mailed to me.

I understand that the session must be in a quiet, private space that is free of distractions.

I understand I cannot record any of the sessions which take place via telehealth.

Billing of Telehealth Services:

I understand Lori Radner, Psy.D.'s biller will bill my telepsychology visits to my insurance company. I understand I am responsible for any applicable deductible, co-insurance or co-pays and the payment policy for services by Lori Radner, Psy.D. and staff also applies to telehealth services.

I have read and understand the information provided above regarding telepsychiatry, I have discussed any questions with Lori Radner Psy.D., P.C. staff (if necessary), and all of my questions have been answered to my satisfaction. By signing below, I indicate I have read, understood and agreed to the entire contents of this consent.

Signature of Parent	Printed Name	Date

Signature of Parent	Printed Name	Date

For parents who are not married with full legal custody:

I have sole legal custody of my child:

Signature of Child's Legal Guardian	Printed Name	Date

PLEASE SELECT YOUR COMMUNICATION PREFERENCES:

I am okay to communicate via email despite risks of confidentiality due to information being sent over the internet_____

I am okay to communicate via fax despite risks of confidentiality_____

I want to avoid all risks and only want to communicate via voice calls and mail_____

Child/Adolescent Patient Information

Please provide the following information and print clearly.

Reason for
Referral:_____
_____
Referred by:_____

Child's full name:_____
Birth date:_____Age:_____
Grade:_____
Home Address_____
_____
Home phone:_____
OK to call you here? Yes___No___

Mother's full name Father's full name

_____ _____
Work phone:_____ Work phone _____
Cell phone:_____ Cell phone_____
O.K. to call you here? Yes___No___ O.K. to call you here? Yes___No___
Email Address:_____ Email Address:_____
Are parents not married? Yes____No____
If not married, who has legal custody of this child?_____
If not married, who has physical custody of this child?_____
In case of emergency, the therapist has my permission to contact:_____
_____Phone_____
Relationship to child_____

Current medications and dose_____
Who is the doctor that prescribed these medications?_____
Does this child have any acute medical conditions, ones that pose an immediate threat to his/her health? (severe allergies, asthma, etc.?) Yes___No___ If yes, please list here:

Please list any current or chronic medical conditions:

Date of last physical exam_____Name of primary care
physician_____ Phone_____
School currently attending:_____Phone_____
Please provide 2 teacher names and email address to send surveys to in order to gather teacher input: Name_____Email Address:_____
Name_____Email Address_____

X._____ **X.**_____
Signature of parents and/or parent and/or guardian completing this form and date signed.

Lori Radner PsyD, L.P. 248-788-6400 Ext. 2

Consent to Disclose Information Form

I, _____, guardian for _____ give my permission for:

1. I will allow the following people to give any pertinent information to Lori Radner:

_____
_

_____

_____
_

2. I would like a report to be mailed to my pediatrician:

Pediatrician's Name:_____

Address:_____

Phone:_____Fax_____

3. I will allow Lori Radner to disclose information regarding treatment/evaluation to the following people:

_____

_____

_____

_____
_

This consent form will be valid for _____after the date signed.

Signature of Patient or Legal Guardian Date

Notice and acknowledgement
Privacy Practice and HIPPA Guidelines of
LORI RADNER, PSY.D., P.L.L.C.

Acknowledgement:

I acknowledge that I am familiar with the HIPPA guidelines and the privacy practices at Lori Radner, Psy.D., P.L.L.C. (see attached policy)

_____
_____
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____
_ _____

Directions to Farmington Hills Office

The office is located in the Park on the Green office complex on the south side of Twelve Mile Road just west of Halstead. It is the second building on the right and there is a B on the outside entrance door. Although the suite number is 250, it is on the first floor on the left when you walk in.

Address:

37899 Twelve Mile Road

Suite 250

Farmington Hills, Michigan 48331

Phone: 248-788-6400 Ext. 2

Fax: 248-788-3840

37899 West Twelve Mile Road
Suite250
Farmington Hills, MI 48331
Phone 248-788-6400 Ext. 2
assessmenttherapy.com

NOTICE OF YOUR RIGHTS

Under the Health Information Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES

How medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WHAT IS HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law, which is intended to offer enhanced protection of personal health information for individuals. It governs how medical and mental health records and other identifiable health information may be used and disclosed by the provider of these services and requires that they are kept properly confidential. In part, it has evolved from the increased concern about digitization of personal information and who can get access to it; however the Act also covers oral and written records and their disclosures. It provides penalties for covered entities (such as service providers) that misuse your personal information.

When the State of Michigan has more restrictive and/or protective laws than HIPAA, these will supersede the federal rules. In most cases, you will find that the privacy practices followed by your psychologist have met or exceeded these guidelines already.

DISCLOSURE OF PHI (PROTECTED HEALTH INFORMATION)

With your consent, PHI can be disclosed for treatment, payment and health care operations. Treatment refers to the direct provision of mental health services and can include coordination of activities that relate to delivery of those services. Payment involves activities such as billing. Health care operations refer to those activities that relate to the performance and operation of the mental health practice of your psychologist, such as administrative or case management functions. “Disclosure” applies to activities outside your psychologist’s office, such as releasing, transferring, or providing access to information about you to other parties. This consent is obtained usually at the outset of treatment and remains in effect unless you revoke it in writing. You may not revoke it to the extent that your psychologist has already relied on it or if it was obtained as a condition of obtaining payment by a third party.

Under HIPAA, monitoring, test results, treatment plans, modality and frequency of treatment, and summaries of treatment, diagnosis, functional status, symptoms, prognosis or progress are part of PHI.

WHAT ARE SOME EXAMPLES OF PROTECTED HEALTH INFORMATION (PHI)? HOW ARE PSYCHOTHERAPY NOTES TREATED?

In effect, PHI refers to individually identifiable health information relating to the condition of the patient, the provision of health care to the individual, and/or payment of care. It is collected and maintained in the course of the assessment, consultation, and/or treatment of the person seeking mental health care form a designated professional provider.

HIPAA recognizes that certain types of mental health information need to be protected more carefully. This provision defines psychotherapy notes as notes, which may contain information, which is unnecessary or inappropriate for "medical record" as defined by the rule. However, because the rules can be applied differently, please read the following sections to understand some of the differences in disclosure of PHI (Protected Health Information) from "psychotherapy notes.

DISCLOSURE OF PSYCHOTHERAPY NOTES

Provided such notes are maintained separately from the medical record, your psychotherapy notes will only be released with a special consent or authorization specific to the disclosure. Without your express consent, this part of the record must be kept private, but may also be disclosed without consent or authorization in same circumstances as the exceptions noted for the non-authorized disclosure of PHI (see next section).

WHEN PHI MAY BE DISCLOSED WITH NEITHER CONSENT NOR AUTHORIZATION

As with Michigan law, HIPAA provides that your permission need not be given for the disclosure of PHI under the following conditions:

- FOR THE PURPOSE OF REPORTING SUSPECTED CHILD ABUSE/NEGLECT
- FOR THE PURPOSE OF REPORTING SUSPECTED DOMESTIC OR ADULT ABUSE
- IN THE EVENT OF A SERIOUS THREAT TO SELF OR THE SAFETY OF OTHERS
- IN THE COURSE OF CERTAIN JUDICIAL, HEALTH OVERSIGHT, AND ADMINISTRATIVE PROCEEDINGS
- IN THE COURSE OF COMPLYING WITH LAWFUL DISCLOSURE IN CASES INVOLVING WORKER'S COMPENSATION

WHAT ARE MY RIGHTS AND WHAT RIGHTS AND RESPONSIBILITIES DOES MY PSYCHOLOGIST HAVE?

You have the right to request restrictions regarding the disclosure of the PHI (protected health information) as provided by HIPAA; however, your psychologist has the right not to agree to a requested restriction. You have the right to receive confidential communications by alternative means and at alternative locations. You also have the right to inspect and copy your PHI. You have the right to amend your medical record, but this request can be denied by your psychologist. You have the right to an accounting of disclosures of your record and the right to a paper copy of this notice from your psychologist upon request.

Your psychologist is required by law to maintain the privacy of your PHI as defined in the HIPAA Act. He/she is also required to provide you with this notice of his/her legal duties and privacy practices with respect to PHI. Your psychologist has the right to change the privacy policies and practices described in this notice. Unless you are notified (for example, by mail) of such changes, however, your psychologist is required to abide by the terms currently in effect.

You will be asked to sign a patient consent form, which asserts that you have read and understand the information in this notice. This will be kept in your medical record and will stand as your authorization to disclose PHI for reasons of treatment, payment, and health care operations. You will have the right to review the Privacy Notice prior to signing consent.

WHAT IS THE COMPLAINT PROCEDURE?

If you believe your privacy rights have been violated, you may file a written complaint (without retaliation) with your psychologist or you can contact:

The U.S. Department of
Health & Human Services
Office of Civil Rights 200
Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
1-800-696-6775

HOW CAN I FIND OUT MORE ABOUT HIPAA?

This brochure represents a summary of your rights regarding mental health related records under the Health Insurance Portability and Accountability Act. For more detailed information, you can contact the U.S. Department of Health and Human Services, Office of Civil Rights (see previous section) or you can visit the government web site:

www.hhs.gov/ocr/hipaa/