

Consent and Agreement for Psychological Testing and Evaluation

HIPAA Overview

The Health Insurance Portability and Accountability Act (HIPAA) is 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 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.

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.

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, 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.

IV. Patient's Rights and Psychologist's Duties

Patient'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 Psychotherapy Notes unless we determine that release would be harmful to your 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 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.
- Tests and test results will be kept in a locked, safe place onsite for two years and at a secure offsite location for eight 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 Steve Peskin, Controller for Premier Psychological Services by telephone at (713) 521-7575 or in writing to: 3730 Kirby Drive, Suite 800 Houston, TX 77098.

CONSENT

I understand that these services may include direct, face-to-face contact, interviewing, testing, and a follow-up appointment to receive the results of testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, 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 I can to make sure that the findings are accurate. I also hereby seek and consent to take part in the psychological testing and evaluation.

I, _____, authorize Premier Psychological Services to perform an initial assessment, psychological testing or evaluation and follow-up test results on _____. (patient's name)

I understand that this evaluation is to be done for the following purpose: _____
_____.

BILLING AND PAYMENTS

The client assumes 100% responsibility for all services, including any and all balances from pre-approved insurance coverage. I understand that the fee for this (these) service(s) will be \$200 for the initial diagnostic assessment and \$150 per hour for subsequent scheduled appointments (which may include further testing or therapy services). The rate of insurance reimbursement varies according to individual insurance contracts and I understand that I will be reimbursed based on my own health plan benefits and that I can request a "superbill" (a more detailed invoice) from Premier 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 payment for these services.

Your signature below indicates that you have read the information in the Consent and Agreement for Psychological Testing and Evaluation and agree to abide by its terms during our professional relationship.

Patient's Printed Name

Patient's Date of Birth

Signature of client (or parent/guardian)

Date

Witness Signature

Date

_____ Original to patient's chart

_____ Copy of HIPAA document to patient/guardian