Ohio Apex Neuropsychology Center Child Patient Packet (Ages 13 and Under)

Date_____

Who referred you or how did you hear about the office?_____

Patient Name_____

Birth Date_____ **Age**_____ **Gender: Female Male Transgendered**

Social Security Number_____

Relationship Status: Single Married Separated Divorced Widowed Partnered

Home Street Address_____

City_____ **State**_____ **Zip Code**_____

Cell Phone_____

May we leave a message on your cell? Yes No

May we text appointment reminders? Yes No

Home Phone_____

May we leave a message at home? Yes No

Email_____

May we send appointment reminders via email? Yes No

Emergency Contact Name _____**Relationship**_____

Emergency Contact's Phone Number_____

Patient's Primary Care Doctor/Pediatrician's Name__

Please Complete The Insurance Information Below

<u>If You Are Not</u> The Insurance Policy Owner:

Policy Holder's Name_____

Policy Holder's Birth Date_____

Relationship To Policy Holder_____

Policy Holder's Social Security Number Needed For Tricare_____

Patient's Social Security Number Needed For Champ Va Benefits_____

I Understand That If I Am Not The Policy Holder That Explanation Of Benefits May Be Sent To The Policy Holder's Address By The Insurance Company ____ (Patient's Initials).

Responsible Party For Payment Of Services (If Not Yourself)

I Understand That Statements Will Be Sent To The Address Below _____ (Patient's Initials).

Name_____

Relationship To Patient_____

Address_____

City_____**State**_____**Zip**_____**Phone**_____

If under 18, Please complete Parent and Guardian Section Below

Mother or Guardian's Name_____

Mother Home Street Address_____

City_____ **State**_____ **Zip Code**_____

Does the patient live with this person? Yes or No

Cell Phone_____

May we leave a message on your cell? Yes No

May we text appointment reminders? Yes No

Home Phone_____

May we leave a message at home or work? Yes No

Email_____

May we send appointment reminders via email? Yes No

Father _____

Father's Home Street Address_____

City_____ **State**_____ **Zip Code**_____

Does the patient live with this person? Yes or No

Cell Phone_____

May we leave a message on your cell? Yes No

May we text appointment reminders? Yes No

Home Phone_____

May we leave a message at home? Yes No

Email_____

May we send appointment reminders via email? Yes No

The Patient's School's Name_____

School Address_____

City_____State_____Zip_____Phone_____

Grade_____

Teacher's Name_____

Ohio Child Informed Consent Form

PARENTAL CONSENT FORM

I (We) voluntarily consent to psychological treatment for my (our) child by a behavioral health clinician at Apex Psychological Care and Memory Center.

I (We) understand that, as an adjunct to my (our) child's treatment at Apex Psychological Care and Memory Center, I (we) may be asked to participate in treatment.

I (We) understand that I (we) retain responsibility for my (our) child while he/she is in treatment at Apex Psychological Care and Memory Center.

I (We) understand that in the event of an emergency situation, as determined by the staff of Apex Psychological Care and Memory Center, I (we) am (are) expected to respond promptly to requests for assistance from the staff.

I (We) understand and agree that should I (we) be unable, for any reason, to respond to such a request, Apex Psychological Care and Memory Center should and will take whatever steps the staff deems necessary and appropriate to resolve the situation.

I (We) understand that, in situations where relevant, the non-custodial parent has legal access to clinical records of Apex Psychological Care and Memory Center, without the custodial parent's consent.

I (We) agree that my (our) child's clinician's role is limited to providing treatment and that I (we) will not involve my (our) child's clinician in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

I (We) agree that I (we) will not ask my (our) child's clinician to testify in court, whether in person, or by affidavit.

I (We) agree to instruct my (our) attorney(s) not to subpoena my (our) child's clinician or to refer in any court filing to anything my (our) child's clinician may have said or done.

I (We) have read the confidentiality agreement included in this packet.

NEUROPSYCHOLOGICAL OR PSYCHOLOGICAL TESTING PROCEDURE

Neuropsychological testing usually involves two to three visits depending upon your situation and if a test authorization is required by your insurance. First, your psychologist will conduct an interview asking questions regarding your symptoms, functioning, and your social, developmental, substance/use, psychiatric, and medical history. Neuropsychological or psychological testing uses various tests to assess your thinking and behavior in order to aid in your diagnosis, determine your level of functioning, and treatment needs. Neuropsychological or psychological testing involves you taking many different kinds of tests which an examiner will administer to you through a variety of methods. These methods may include interacting with the examiner, completing questionnaires, and doing tasks on a computer. The neuropsychological or psychological tests may examine your behavior, personality, intelligence, attention, learning, memory, reasoning, judgment, perceiving information, problem solving, language, motor speed, ability to organize and plan information, and ability to carry out complex tasks. The types of tests and the length of a testing session depends upon: the problems you are having, your age, history of prior testing, and education and occupational achievement. Your tests will be scored once you have completed the testing. Your scores will be compared to individuals who are similar to you in order to determine whether or not you have a memory disorder, thinking disorder, or a psychological problem. During the last visit, you will meet with the psychologist who will go over your test results and the recommendations the psychologist has made. Test reports will be released to other parties with your permission if your balance is paid in full.

PSYCHOTHERAPY TREATMENT

Psychotherapy uses many different techniques to help you learn strategies to cope with the problems that you are facing. Your first session will involve an evaluation of your needs. By the end of the evaluation, your clinician will discuss your preliminary diagnosis, treatment recommendations, and their opinion of whether they have the expertise to help you. If you and your clinician decide to pursue psychotherapy, he or she will typically schedule one session on a weekly or biweekly basis until you start feeling better. Then, your clinician will taper sessions or end therapy after you see improvement in your symptoms.

MINORS

If you are under eighteen years of age, please be aware that the law states that your parents have the right to examine your treatment records unless a court determines that it is not in their best interest.

EMERGENCY CALLS

If a life threatening emergency occurs, please go to the local emergency room and/or call our office at 330-953-1354 (Ohio) or 724-512-0900 (Pennsylvania), where our staff will contact your clinician and relay the message to them about your situation. If you are unable to get in contact with your clinician, then go directly to your local emergency room.

SCHEDULING APPOINTMENTS/LATE CANCELLATIONS/NO SHOWS

Please call our office at 330-953-1354 (Ohio) or 724-512-0900 (Pennsylvania) to schedule an appointment. If you did not pay your share of healthcare costs (e.g., copay, coinsurance, or deductible) at the time of your visit, you will not be allowed to schedule a future appointment(s) until your balance is paid in full unless a payment plan is agreed upon. If you do not show for an appointment or provide at least 24 hour notice when cancelling an appointment, you will be required to pay a $55 fee. The no show or late cancellation fee must be paid and/or a payment plan must be agreed upon in order for future appointments to be scheduled. If another appointment has been previously scheduled, this appointment may be cancelled if you have an outstanding balance unless a payment plan is agreed upon.

PROFESSIONAL RECORDS

The laws and standards of your clinician's profession require that they keep mental health treatment records. You are entitled to receive a copy of your record unless your clinician believes that seeing them would be emotionally damaging. Your mental health record can be misinterpreted and/or upsetting to untrained readers. Therefore, it is recommended that if you choose to view your mental health record that you review them in the presence of your clinician so that he or she can discuss the contents and answer any questions you may have. You will be charged an appropriate fee for copying your records and any time spent in preparing information requests (see financial policy section).

CASE CLOSED OR BEING DISCHARGED FROM TREATMENT

Your case will be closed if you have not returned for treatment within 30 days of your last appointment. Your case can be re-opened unless you have had three (3) no show and/or late cancellation appointments in the past three months or if you have a past due balance with no payment being made to your account in 60 days. We will gladly assist you in finding another provider if the above situation(s) should arise.

ELECTRONIC COMMUNICATION POLICY

This outlines our office policies related to the use of electronic communications. Our electronic communications policy will hopefully assist you in understanding how our clinicians and office staff interact with patients through electronic communications methods. Please be aware that email, text, and social media communications are generally not secure means of communication and can be easily accessed by unauthorized people. Therefore, the confidentiality of email, text, and social media communications is not guaranteed.

EMAIL COMMUNICATIONS

Email communications are generally not secure means of communication and can be easily accessed by unauthorized people. Therefore, the confidentiality of email communications is not guaranteed. Email appointment reminders may be given if you elect to receive this type of reminder. If you choose to contact our office through email, our office staff and clinicians will only respond to emails for administrative purposes such

as changing appointments, billing matters, and other administrative related matters. Please do not email your clinician about personal matters as email communications are not secure ways to contact your clinician. Please call the office to set up an appointment with your clinician to discuss personal matters.

TEXT MESSAGING
Text messaging is another unsecure mode of communication. Text appointment reminders may be given if you elect to receive this type of reminder. Our office staff and clinicians will not have the capability to respond back to texts. Please do not text your clinician about personal matters as text communications are not secure ways to contact your clinician. Please call the office to set up an appointment with your clinician to discuss personal matters.

SOCIAL MEDIA
Our staff and clinicians do not accept friend or contact requests from current or former patients on social networking sites. Our staff and clinicians do not communicate with, or contact, any of our patients through social media platforms like Twitter, Facebook, Instragram, Linkeden, etc. In addition, if our staff and/or clinicians discover that they have accidentally established an online relationship with a patient or former patient, our staff or clinician will cancel that relationship on the social networking site. Our office believes that adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. Please do not try to contact staff or clinicians through their personal social media networking site(s). Our staff and clinicians will not respond to any contact through their personal social media networking site(s).

WEBSITE
Our office has a website (www.apexpsychcare.com) that you are free to access to obtain information about our practice.

FINANCIAL POLICY

INSURANCE PLANS ACCEPTED
We accept most insurance plans. We will do the best to help you interpret your health care benefits, but it is ultimately your responsibility to understand the services which are covered and not covered under your plan. In some cases, insurance companies require pre-authorization prior to seeking treatment. We will attempt to obtain the authorization for you; however, some insurance companies require that you obtain your own authorization. Insurances will be billed and paid at the contracted rate with your insurance company. You are responsible for copay/coinsurance, deductible payments, and claims or fees that your insurance company does not cover.

BILLING YOUR INSURANCE
We will bill your insurance company. You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans/summaries or copies of the entire record (in rare cases). This information will

become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with your information once they receive it. In some cases, they may share the information with a national medical information databank.

BILLING AND PAYMENTS
You will be expected to pay for each session or pay your copay/coinsurance/deductible on the appointment date. Payment schedules for other professional services not listed above will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the collection agency and/or small claims court costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. In addition, if you have an account balance and no payments have been made in 60 days, then you will be discharged from our practice.

FEES
Please ask our receptionist or clinician for the current year fee schedule. In addition, our fee schedule is located in the waiting room for you to review.

MEDICAL RECORDS AND FORM COMPLETION REQUESTS
Medical forms for clinicians to complete fee: $32.00 for first four pages and $8.00 for each page thereafter. Copy of records fee when patient or patient representative request it: first 10 pages $1.58 per page; pages 11 to 50 additional $.68 for each page; pages 51 and higher additional $.27 for each page. Copy of medical records fee when the request is made by other than patient: Retrieval Fee $20.06; Plus $1.32 per page for first ten pages; pages 11 to 50 additional $.68 for each page; pages 51 and higher additional $.27 for each page.

LEGAL PROCEEDINGS THAT REQUIRE YOUR CLINICIAN'S PARTICIPATION
You will be expected to pay for your clinician's professional time even if your clinician is called to testify by another party. We charge $380.00 for the first hour (one hour minimum) and $190.00 for each hour thereafter for preparation and attendance at any legal proceeding. Full day attendance at a court proceeding will be charged a flat rate of: $1,710. If the clinician is required to travel to the legal proceeding, you will be charged for the clinician's miles to the legal proceeding and the rate will be the Internal Revenue Rate for miles from the clinician's office.

Ohio Confidentiality Agreement

In general, the privacy of all communications between a patient and a mental health professional is protected by law, and we can only release information about the content of your sessions/evaluations to others with your permission. However, there are a few exceptions**:** 1) If you threaten to harm yourself, we are obligated to seek hospitalization

for you or contact your family members or others who can help provide protection for you. 2) If you threaten serious bodily harm to another individual(s), we are required to take protective actions. These actions may include: notifying the potential victim(s), contacting the police or other authorities, or seek hospitalization for you. 3) If you are under the age of 18 (or under the age of 21 if you are mentally retarded, developmentally disabled, or physically impaired), we are required to report to authorities if you are being abused (e.g., emotionally, physically, sexually, or being neglected) or if you are facing the threat of being abused. 4) If you are over the age of 60 and are a vulnerable older adult (i.e., physically or mentally impaired to the point of being unable to provide his or her own care or protection), we are required to report to authorities if you are being abused (e.g., emotionally, physically, sexually, being exploited, or being neglected). 5) If the court orders (not subpoenas) your medical record, we will have to relinquish your records to the court. However, we will attempt to discourage the court from doing this. If you file a lawsuit against our office or file a complaint with the state licensing board, we will be required to release your medical records to the lawyers and/or licensing board. 6) If you are using insurance or another third party payer, our office must share certain information with them, including, but not limited to: diagnosis(es), the dates of your visits, symptoms, treatment progress, and occasionally your treatment notes. 7) The confidentiality of email and text communications is not guaranteed as these are not secure modes of communication.

CONSENT TO TREATMENT AND TO TERMS OF THIS AGREEMENT

I am the legal authorized individual to consent to treatment and to make medical decisions. I voluntarily consent to evaluation and treatment by a clinician at Apex Neuropsychology Center. I acknowledge that no guarantees have been made to me as to the result of this evaluation or subsequent treatments. My signature below means that I understand and agree with all the terms that are in this agreement. **Please note Guardians and/or Power of Attorneys must provide a copy of the legal documentation of Guardianship and/or Power of Attorney** agreement in order to be able to sign this agreement for the patient otherwise the patient must sign this agreement.

Name of Minor _____ **Date** _____

Signature of Parent or Guardian _____ **Date**_____

Signature of Parent or Guardian _____ **Date**_____

Witness _____ **Date**_____

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION NOTICE OF PRIVACY PRACTICES

When we examine, test, diagnose, treat, or refer you, we will be collecting what the HIPPA privacy law calls, “Protected Health Information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although, we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. You have the right to revoke your consent to our privacy practices by writing your revocation to our privacy officer. We will then stop using or sharing your PHI, but we may have already used or shared some of it, and we cannot change that. By signing this form, you are also agreeing to let us use your PHI and to send it out to others for the purposes described above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information**. If you do not sign this form agreeing to our privacy practices, we cannot treat you.** In the future, we may change how we use and share this information and so we may change our notice of privacy practices. If we do change it, you can get a copy from our privacy officer, Courtney, by calling 330-953-1354.

My signature below means that I understand and agree with all of the terms above.

_____

Patient or Legal Guardian or Power of Attorney Sign Here **Date**

_____

Witness Sign Here **Date**