Flagstaff Counseling Center
408 N Kendrick, Suite 4 ● Flagstaff, Arizona 86001
(928) 774-6364 Phone ● (928) 556-0504 Fax

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Informed Consent For Psychological Evaluation

Welcome to Flagstaff Counseling Center (FCC). This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician. Your signature at the bottom indicates that you understand the information and freely consent to participate in this evaluation.

TESTING

Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you here for this assessment. These questions generally relate to Attention-Deficit/Hyperactivity Disorder (ADHD), but may concern other diagnostic questions as well . Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations.

The assessment process generally involves an informational interview followed by the administration of one or more psychological tests. Although it is sometimes possible to complete the testing procedure in one sitting, it is not uncommon for people to be asked to return for another session to finish the assessment battery. Once testing is completed, the data will be analyzed, and a report will be written. You will then have the opportunity to meet with your clinician to discuss the results and receive a copy of the report. Our general turnaround time is 2-4 weeks. This may take longer if certain forms are not returned to the evaluator for scoring/interpretation.

TYPES OF MEASURES

The type(s) of measures you/your child may receive include:

- Diagnostic Interview and Developmental History – to obtain information about the examinee outside of the testing situation, and to obtain a comprehensive history in order to make a more reliable diagnosis.
- Cognitive Testing – to assess overall intellectual ability, as well as strengths and weaknesses in verbal comprehension and perceptual reasoning.
- Memory Testing – to assess overall intellectual ability, as well as strengths and weaknesses in verbal comprehension, perceptual reasoning, working memory, and processing speed.
- Attention and Executive Functioning Testing – to assess attentional processes, along with any difficulties pertaining to initiation, sustained effort, emotional modulation, ability to monitor and self-correct, working memory, organization and planning.

- Behavior Rating Scales and/or on-site behavioral observation at school in order to get a sample of behavior which occurs outside the office setting.

- Personality Testing- to assess personality structure and characteristics that may be linked with certain psychological disorders.

FEEDBACK

The type(s) of feedback you/your child will receive may include:

- A comprehensive written report that provides findings for each measure, an integrative summary, and recommendations for treatment and/or other interventions.

- A brief, written summary report that provides an overview of findings and recommendations.

- In-person, verbal feedback.

FEE AND PAYMENT POLICY

The total fee for an evaluation varies based on total time of the evaluation and time used to score/analyze the tests and write the report. The total fee for an evaluation will be lower for a brief, written summary of the report in lieu of a full comprehensive report. Our hourly rate for psychological evaluation is $120/hour for direct pay clients. We also accept Blue Cross Blue Shield and United Healthcare insurance. If you choose to bill through your insurance, please read the following section carefully.

If you are going through a contracted EAP, we will bill as many 1-hour units toward your EAP that is allowed for the year. Any remaining units will be billed to insurance or will be self-pay.

Please also note that we charge for missed appointments/late cancellations that are not within 24 hours notice. This fee is $50/hour of blocked time for the evaluation.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for psychological evaluation services. Your clinician will provide you with whatever assistance they can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

You should also be aware that most insurance companies require that your clinician provide them with your clinical diagnosis. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, your clinician has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. You will be provided with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize your clinician to release such***

information to your insurance company. Your clinician will try to keep that information limited to the minimum necessary.

RELEASE OF RECORDS

Written records are released only after a consent form is signed by the client or their Parent/Legal Guardian.

INFORMED CONSENT

I understand that the information obtained in this evaluation is confidential and will not be released to any person or organization without my written permission. (***This release is available in our office or may be completed with any individual whom you wish to give such access, and then provided to us.)*** The only exceptions to this policy are rare situations in which you are required by law to release information with or without my permission. These are: 1) if there is evidence of physical and/or sexual abuse of children or abuse to the elderly; 2) if you judge that I am in danger of harming myself or another individual; and 3) if my records are subpoenaed by the court. In the rare event of any of these situations, you would attempt to discuss your intentions with me before an action is taken, and you would limit disclosure of confidential information to the minimum necessary to ensure safety.

I understand that if my evaluating clinician at FCC deems that additional or alternative testing be necessary, my clinician will describe the reasons for this testing and will advise me of any additional costs. I understand that I have the right to discontinue the evaluation process at any time. However, I understand that my evaluating clinician may be unable to provide feedback of the test results if testing is terminated, and that I will still be responsible for payment of any testing, scoring, and evaluation time provided up until that point.

By my signature below, I acknowledge that I consent to a psychological evaluation by Flagstaff Counseling Center, that I have been informed of the policies regarding evaluations at the FCC and have read the full consent form, and that I agree to all of the payment arrangements outlined in this form. I fully understand my rights and obligations as a client at FCC and I freely agree to this assessment.

Client/Guardian Signature _____ Date_____

Evaluating Clinician Signature _____ Date_____

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) for Protecting Client Behavioral Health Information

THIS NOTICE DESCRIBES HOW BEHAVORIAL HEALTH INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures of your health information

FCC may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes without your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your medical 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 therapist.
  - – Payment is when we obtain reimbursement for your health care. 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. This does not apply to Employee Assistance Program billing.
  - – 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 FCC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of FCC such as releasing, transferring, or providing access to information about you to other parties.

In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

II. Uses and Disclosures Requiring Authorization

FCC may use or disclose PHI for purposes outside of treatment, payment, or 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 or health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations 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. 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 limited circumstances:

- Child Abuse – We are required to report PHI to the appropriate authorities when we have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- Adult and Domestic Abuse – If you have the responsibility for the care of an incapacitated or vulnerable adult, we are required to disclose PHI when we have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- Health Oversight Activities – If various Arizona Boards overseeing mental health services are conducting an investigation, then we are required to disclose PHI upon receipt of a request for medical records from a Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services we provided you, such information is privileged under state law, and we will not release information without the written authorization of you or your 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.

- Deceased Clients—We may disclose PHI regarding deceased clients as mandated by state law. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate.
- Medical Emergencies—We may disclose your PHI in a medical emergency to medical personnel in order to prevent serious harm.
- Family Members involved in your care--We may disclose information to family members directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- Law Enforcement—We may disclose PHI to a law enforcement official as required by law, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime or deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- Specialized Government Functions—We may review requests from US military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons, and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws, and the need to prevent serious harm.
- Research—PHI may only be disclosed after a special approval process.
- Serious Threat to Health or Safety – If you communicate to us an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and we believe you have the intent and ability to carry out such a threat, we have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police, and in order to initiate hospitalization procedures. If we believe there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.
- Worker's Compensation – We may disclose PHI as authorized by, and to the extent necessary, to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness.

IV. Client's Rights

Client's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- 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. On your request, we will send your bills to another address.
- Right to Inspect and Copy – You have the right to inspect or obtain a paper or electronic copy (or both) of PHI in our mental health and billing records, and any other records used to make decisions about you, for as long as the PHI is maintained in the Medical record. We may deny your access to PHI only where there is compelling evidence that access would cause serious harm to you.
  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 medical record. We may deny your request. You have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement.
- Right to an Accounting of Disclosures– You generally have the right to receive an accounting of disclosures of your PHI. On your request, we will discuss with you the details of the accounting process.
- Breach Notification – If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your medical records, you may contact this office. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW Washington, DC 20201. We will not retaliate against you for filing a complaint.

VI. Changes to Privacy Policy

- We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a copy of the revised practices by posting a copy on our website or providing one to you at your next appointment.

_____ _____

Signature Date

ADULT CLIENT INFORMATION FORM

CLIENT INFORMATION:

LEGAL NAME_____

DATE: _____

MAILING ADDRESS_____

CITY/STATE_____ZIP_____

CELL PHONE_____

WORK PHONE _____

HOME PHONE _____

EMPLOYER _____

DATE OF BIRTH_____

MARITAL/PARTNERSHIP STATUS_____

EDUCATION LEVEL_____

EMERGENCY CONTACT:

FULL NAME_____

TELEPHONE_____

RELATIONSHIP TO CLIENT_____

INSURANCE INFORMATION:

PRIMARY POLICY HOLDER _____

IF NOT SELF, HOW ARE YOU RELATED TO THE INSURED?_____

DATE OF BIRTH_____

INSURANCE NAME_____

ADDRESS _____

CITY/STATE_____ZIP_____

INSURANCE ID#_____

GROUP # _____ CO-PAY_____

DEDUCTIBLE AMOUNT_____

EFFECTIVE DATE _____

IS THERE A SECONDARY POLICY? ___YES ___NO

IF YES, NAME OF INSURED _____

SECONDARY INSURANCE COMPANY _____

FINANCIALLY RESPONSIBLE PARTY:

FULL NAME_____

MAILING ADDRESS_____

CITY/STATE_____ ZIP_____

TELEPHONE_____

SPOUSE/PARTNER (IF APPLICABLE):

NAME_____

DATE OF BIRTH_____

MAILING ADDRESS_____

CITY/STATE_____ ZIP_____

PHONE _____

EAP BENEFIT INFORMATION:

EMPLOYEE'S FULL NAME_____

IF NOT SELF, HOW ARE YOU RELATED TO THE EAP EMPLOYEE? _____

EMPLOYER_____

YEARS AT THE COMPANY _____

HAS THE EAP BENEFIT BEEN USED BY YOU OR A FAMILY MEMBER THIS YEAR? ___YES ___NO

IF YOU WERE REFERRED TO OUR OFFICE, WHO REFERRED YOU?_____

CHILDREN & OTHER FAMILY MEMBERS

NAME	RELATION	SEX	DOB	AGE	GRADE	SCHOOL/ EMPLOYER

CLIENT INFORMATION FOR ADULT CLIENTS

Family Physician(s)_____ Allergies_____

Medications _____

_____ _____

How helpful are your medications? _____

Health and Wellness Concerns	Self	Spouse/Partner
Arthritis	_____	_____
Asthma	_____	_____
Breathing problems	_____	_____
Diabetes	_____	_____
Dizziness or fainting	_____	_____
Heart problems	_____	_____
Head injury	_____	_____
High blood pressure	_____	_____
High cholesterol	_____	_____
Headaches	_____	_____
Lack of exercise	_____	_____
Low energy	_____	_____
Poor nutrition	_____	_____
Sleep problems	_____	_____
Smoker	_____	_____
Thyroid problems	_____	_____
Weight issues	_____	_____

In the last year, have you ever drank or used drugs more than you meant to? Y ☐ N ☐

Has your alcohol or drug use interfered with your job or family life? Y ☐ N ☐

Have you ever felt that you needed to cut down on your drinking or drug use? Y ☐ N ☐

Does anyone in your family have an alcohol or drug problem? Y ☐ N ☐

Other medical problems? _____

_____

Psychological Concerns	Self	Spouse/Partner
Agitated	_____	_____
Alcohol abuse	_____	_____
Angry	_____	_____
Anxious or nervous	_____	_____
Attention problems	_____	_____
Appetite change	_____	_____
Bad childhood	_____	_____
Career	_____	_____
Child abuse	_____	_____
Confidence	_____	_____
Depression	_____	_____
Disciplining children	_____	_____
Divorce	_____	_____
Domestic violence	_____	_____

CLIENT INFORMATION FOR ADULT CLIENTS

Psychological Problems	**Self**	**Spouse/Partner**
Drug abuse	_____	_____
Eating disorders	_____	_____
Elderly parents	_____	_____
Emotional abuse	_____	_____
Fears	_____	_____
Financial problems	_____	_____
Friendships	_____	_____
Gambling	_____	_____
Grieving	_____	_____
Hallucinations	_____	_____
Jealousy	_____	_____
Legal problems	_____	_____
Loneliness	_____	_____
Marriage/partnership	_____	_____
Memory problems	_____	_____
Mental illness	_____	_____
Mood swings	_____	_____
Nightmares	_____	_____
Obsessions/compulsions	_____	_____
Panic attacks	_____	_____
Parenting	_____	_____
Poor communication	_____	_____
Poor concentration	_____	_____
Problems with relatives	_____	_____
Pushing or hitting	_____	_____
Relationships	_____	_____
School problems	_____	_____
Self-esteem	_____	_____
Sexual affairs	_____	_____
Sexuality concerns	_____	_____
Shyness	_____	_____
Sibling conflicts	_____	_____
Stressed	_____	_____
Suicidal thoughts	_____	_____
Threats or use of weapons	_____	_____
Traumas	_____	_____
Violent thoughts	_____	_____
Work issues	_____	_____

Other psychological problems? _____

_____

Previous counseling? Yes_____ No_____ When_____Counselor(s)_____

Problems at that time?_____

Reason you are here today?_____ _____

_____ _____