COMPLETE NEUROPSYCHOLOGY SERVICES
for children, adults, and older adults

2000 Hogback Road, Suite 2, Ann Arbor, MI 48105
1056 Charles Orndorf Drive, Suite G, Brighton, MI 48116
500 Perry Road, Suite 202, Grand Blanc, MI 48439
www.completenp.org Phone: (734) 386-0041 Fax: (734) 480-8870

CLINIC POLICIES & INFORMED CONSENT FOR IN-PERSON & ONLINE SERVICES

WELCOME! We are happy you have chosen to work with us! We understand what a big step you have taken in seeking out services. As helping professionals, we strive to do work that enhances your life and your family's life. That is our mission!

CONTACT & LOCATION INFORMATION

We have three office locations: Ann Arbor, Brighton, and Grand Blanc.

Please send all mail to the Brighton address:

Complete Neuropsychology Services, Inc.
1056 Charles Orndorf Dr., Suite G
Brighton, MI 48116

Our other locations are located at:

2000 Hogback Rd., Suite 2
Ann Arbor, MI 48105

and

500 Perry Rd., Suite 202
Grand Blanc, MI 48439

Please use our main phone number for all matters: **(734) 386-0041**.

Office staff is available by phone Monday – Friday, 9:00 AM – 4:00 PM.

Our fax number is: **(734) 480-8870**
Our website is found at: **www.completenp.org**
Our office email is: **office@completenp.org**

The office email is monitored by office staff. If you want to email your provider, please put the provider's name in the subject line.

GENERAL CLINIC POLICIES

- Our offices are open *by appointment* only. Please do not stop by our office without an appointment. This is to maintain privacy of other clients.
- Co-pays are due the day of service. Account balances are due upon receipt.
- If you have a recurring therapy appointment, we require a credit card on file.
- 24-hour notice is required for cancellation, except in emergency situations. We charge a $45 fee for late cancellation and no-shows.
- We are not able to provide emergency, or urgent services, or after-hours services. In the event of an emergency please call 911 or go to an emergency department.
- If you want your provider to complete forms outside of your session time, then you will be billed for this service at the provider's hourly rate.

I understand and agree to the above: ____

RECORD ACCESS & RECORDS REQUESTS

Access to your records

- You can easily get access to your medical record or your child's record. To do so, contact our office via phone or email (office@completenp.org). You will be asked to complete a **Record Access Request** form.

Request to send record to a third-party

- If you are requesting your record be sent to a third-party, then you will need to complete and sign a **Release of Information Authorization** form.

I understand and agree to the above: ____

INSURANCE

- Our providers participate with most insurance plans. Your insurance plan may cover all or part of the cost of services.
- You will be billed for costs of services that are not able to be billed to your insurance or are not covered by your insurance.
- Your insurance company has the right to request all of your patient records. In the course of regular business, your insurance company will be aware of your current diagnoses and services provided to you.

I understand and agree to the above: ____

PAYMENT FOR SERVICES

- Co-pays are due on the day of service. Account balances are due upon receipt.
- If you have a recurring therapy appointment, we require a credit card on file. We will charge your credit monthly for co-pay/co-insurance balances.
- If you have an unpaid balance for therapy services $\geq$ $300, then your sessions will be temporarily paused until you make payment arrangements with the office manager, Lindsey Palazeti (lpalazeti@completenp.org)
- You will receive monthly invoices with your balance.
- Payment on your account can be made with a credit card over-the-phone or online via an invoice emailed to you (we use SQUARE and EASY PAY for credit card transactions), or via your patient portal.
- We accept Visa, MasterCard, Discover, and American Express.
- We do not keep cash on the premises and are not able to make change.
- If you do not pay for services as previously agreed upon, the clinic reserves the right to attempt to collect the debt via a third-party collection service.

I understand and agree to the above: ____

NEUROPSYCHOLOGICAL EVALUATION

If you or a family member are being seen for a neuropsychological evaluation, please read and acknowledge the following information:

- Most insurance plans will not cover all the costs of neuropsychological evaluation. Self-pay is available for non-Medicaid clients (Medicaid prohibits us from charging their clients out-of-pocket).

- A neuropsychological evaluation is a PROCESS that occurs over the course of several in-person appointments.
- Your evaluation will include clinical interviews; review of records; face-to-face assessment and completion of forms by the client, and others (e.g., parents, teachers, spouse/partner)
- The neuropsychologist may want to consult other professionals involved in your care.
- The neuropsychologist will likely request outside records (such as report cards, evaluation reports, school accommodations plan, brain imaging reports, visit notes from physicians, etc.) that the provider deems important to the evaluation.
- Testing appointments take several hours. A second testing appointment may be necessary to complete the evaluation.
- When the evaluation process has been completed and all requested information has been received (including rating scales, history forms, and outside records), you will meet with the neuropsychologist to discuss the test scores.
- You will be provided with a summary of your test results as part of your medical record.

I understand and agree to the above: ____

NEUROPSYCHOLOGICAL/PSYCHOLOGICAL REPORTS:

- A neuropsychological report is a time-intensive document that takes several hours to complete. Report writing time is in addition to face-to-face testing and may not be covered by your insurance.
- You must request a report, if desired.
- A neuropsychological report will be released when the testing balance has been paid in full. (Note: A summary of your test results is available in lieu of a full report.)

I understand and agree to the above: ____

CONFIDENTIALITY & INFORMED CONSENT FOR THERAPY & EVALUATION

- In most instances, information that you provide during the evaluation is kept strictly confidential.
- There are, however, some limits to this confidentiality such as in the case of threat of harm to self or others, suspected child abuse or abuse of a vulnerable adult, or when release of your record is otherwise required by law (such as in the event of a court order).
- You will be made aware of potential disclosures before they are made, when appropriate.
- CNS is a training clinic. Sometimes your provider will have advanced trainee observing or working with the provider. A trainee will never oversee your care, however.
- Additionally, your provider may discuss aspects of your case during peer consultation with other professionals or for training purposes, w*hile protecting your and your family's identity.*

I understand and agree to the above: ____

SUPERVISION OF LIMITED LICENSE PSYCHOLOGISTS (LLP), LIMITED LICENSED SOCIAL WORKERS (LLMSW), & LIMITED LICENSED COUNSELORS (LLPC)

You may be working with one of our limited licensed providers who work under the supervision of a fully licensed provider.

- Alyssa Gajar, LLMSW - supervised by Erin Mark, PhD and Tiffany Shultz, LMSW
- Brianna Houle, LLMSW - supervised by Erin Mark, PhD and Tiffany Shultz, LMSW
- Breanna Cocagne, LLMSW - supervised by Erin Mark, PhD and Tiffany Shultz, LMSW
- Mason Bushnell, LLMSW - supervised by Erin Mark, PhD and Tiffany Shultz, LMSW
- Madison Markwardt, LLMSW - supervised by Erin Mark, PhD; LMSW; Tiffany Shultz, LMSW, or Joe Petricca, LMSW
- Hassan Nabhan, LLPC - supervised by Erin Mark, PhD or Amy Haun, LPC
- Josephine Caruso-Ruhl, LLP - supervised by Erin Mark, PhD

I understand that if my provider is listed above, they are under the supervision of a fully licensed provider who will have regular access to my therapy notes and details about my case. My provider will meet regularly with the supervising provider to discuss my case. The fully licensed provider will sign-off on all treatment plans, session notes, and bills for service. I am able to request a session with the supervising provider at any time.

I understand and agree to the above: ____

PERMISSION TO RECORD & PHOTOGRAPH

Complete Neuropsychology Services requests your photograph for our records. By signing below, you are giving permission for Complete Neuropsychology Services to record and photograph you. In some cases, we will request video or audio recording that is not stored long-term. This is necessary for some aspects of testing.

Recording: I give my permission for CNS to create a video or audio recording of me for clinical or training/supervisory purposes. I understand this recording will be destroyed after use and not stored permanently.

I understand and agree to the above: ____

Photography: I give my permission for CNS to create and store a photo of me for clinical purposes.

I understand and agree to the above: ____

PARENTS OF ADOLESCENCE AND OLDER CHILDREN

We understand parents want and need to be involved in their child's care, and we encourage parent involvement in the therapy process. However, we must also protect a child's privacy. Privacy allows a child to be open with their therapist, which is crucial to building a solid and effective therapeutic relationship. *To protect privacy, we strongly encourage parents to refrain from requesting their older child's therapy notes*. Your child's therapist can meet with you or can provide a treatment summary, instead.

To receive a treatment summary, please make a request via the office email: office@completenp.org

I understand and agree to the above: ____

TELEHEALTH INFORMED CONSENT AND AGREEMENT

At Complete Neuropsychology Services, our providers may offer you the option of a telehealth visit. That means you may meet with our providers online, via a HIPAA-compliant telehealth online portal, instead of traveling to our offices to meet in-person.

Telehealth sessions are very convenient. They allow clients from long distances to access specialty care that may not be available in their area. Online visits may be more affordable for some clients and may allow clients to meet with providers at more convenient hours. Your provider will decide if telehealth visits are an appropriate method of treatment and will regularly re-evaluate whether telehealth visits continue to be appropriate.

Telehealth sessions are *optional.* You can choose to meet in-person, if that is your preference. Although in-person appointments may not be immediately available.

Despite telehealth benefits, however, there are some limitations. Please read below to learn more about the risks and benefits of our telehealth visit options.

- In our clinic, a *telehealth* session or service refers to delivery of behavioral health services using online video conferencing between a staff member or provider and you, the client.
- To protect your confidentiality, we incorporate network and software security measures to protect the electronic transmission of voice, video, and print data.
- These services rely on digital technology. There are some risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
- Sometimes there are "technical difficulties", or slow connection, poor quality connection or disruption of the online visit. In these instances, it may be necessary to communicate by other means such as by phone call or text to re-establish (i.e. troubleshoot) or reschedule the visit.
- It is your responsibility to maintain privacy in your location. For example, it is your responsibility to have the online session in an area where others cannot easily hear or see the session content. This can be aided by use of headphones.
- Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
- We do not save, record, or store audio or video session data.

The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

I understand and agree to the above: ____

CLIENT AGREEMENT AND CONSENT TO USE TELEHEATH/TELEBEHAVIORAL HEALTH SESSIONS

Electronic Transmission of Information:

I, the undersigned (or my designee on my behalf), agree to participate in technology-based sessions and other healthcare-related information exchanges with Practitioners and Staff at COMPLETE NEUROPSYCHOLOGY SERVICES, INC., a behavioral health care practitioner ("practitioner"). This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app"). I *understand that in-person behavioral health sessions are also available to me at any time*

Equipment:

• I represent that **I am using *my own* equipment** to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

• I understand that I will be informed of the identities of all parties present during the sessions or who have access to my personal health information and of the purpose for such individuals to have such access.

Telebehavioral Health Process:

• My health care practitioner has explained how the telebehavioral health sessions are performed and how they will be used for my treatment. My behavioral practitioner has also explained how the session(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Electronic Presence:

• In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" (*such as Doxy.me*) will be transmitted electronically to and from myself and my practitioner.

Limitations:

• Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

• I understand that telebehavioral health is a relatively new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
• Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.
• *In rare instances, security protocols could fail, causing a breach of privacy of personal health information.*
• *Though we do not store or record your video sessions, it is possible that security measures will be breached resulting in your electronic session data being recorded by others.*

Discontinuing Care:

• I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners.
• I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.
• I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.
• Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality: I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Alternatives: The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.

Compensation:
I understand that I am not entitled to royalties or to other forms of compensation for participation in any telebehavioral consultation(s) or other information exchange.

Emergency Care:
I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

Release of Liability:
I unconditionally release and discharge ***COMPLETE NEUROPSYCHOLOGY SERVICES, INC.***, its affiliates, agents, employees**; DOXY.me**, ***HMS Midwest,*** its affiliates, agents, and employees; and my practitioner and their designees from any liability in connection with my participation in the remote consultation(s).

CONSENT TO TREAT A MINOR WITH TELEHEALTH:

The above release is given on behalf of (client’s name)____, because the client is a minor or has been deemed to be incompetent to give medical consent for the following reasons:

____.

FINAL AGREEMENT:

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

With this knowledge, I voluntarily consent to participate in the in-person and telebehavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Printed name of client: ____

____ ____________________________

Signature of Client/Guardian/Authorized Representative **Date**