



**RICHMOND NEUROPSYCHOLOGY**  
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## **CONSENT and CONTRACT**

Welcome to Richmond Neuropsychology. This document contains important information about my professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

### **NEUROPSYCHOLOGICAL and PSYCHOLOGICAL SERVICES**

Neuropsychology and psychotherapy are not easily described in general statements. They vary depending on the area of expertise of the psychologist, personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Neuropsychological evaluation and psychotherapy are not like a medical doctor visit. Instead, they call for very active effort on your part. In order for the evaluation and therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. There may be forms to complete and “homework” assignments to work on between sessions. These are each customized to best help you.

Neuropsychology and psychotherapy can have benefits and risks. Because they often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, neuropsychological evaluation and psychotherapy have also been shown to have benefits for people who go through it. Results and recommendations from neuropsychological testing and therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

**Neuropsychological Evaluation** begins with an Interview to gather information about your history, areas of difficulty you want to explore. Testing is usually conducted in 2-4 sessions, lasting about 2 hours each session. You will be asked questions and complete tasks on paper and computer-based instruments to compare your abilities to typically developing and same-age peers. The test battery is customized to your situation. It may include measures of attention, executive functions, intelligence, learning, memory, language, nonverbal and visual spatial abilities, as well as behavior, personality, and social skills. After the results are scored and interpreted, a feedback session will be scheduled. The Feedback Session is the time to discuss the results and recommendations. Questions are encouraged. Lastly, we will decide together how detailed of a written report you require for your particular needs. The Written Report is an important document and takes time to prepare. The report is typically completed about 2 weeks after the feedback session, although may require additional time, depending on the circumstances.

**Psychotherapy or Counseling** is also individualized for your situation and goals. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first

impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

## **SESSIONS**

Neuropsychological evaluation typically requires three parts: Interview (1 session and may be combined with the first testing session), Testing (2-4 sessions of approximately 2 hours each), and Feedback (1 hour).

Psychotherapy is a series of appointments, depending on your goals. I normally conduct an evaluation that will last from 2-4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one 45-minute session per week, at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

## **PROFESSIONAL FEES**

My hourly fee is \$150.00. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party.

## **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I 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, its costs will be included in the claim.] In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

## **INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. Please note that you (not your insurance company) are responsible for full payment of my fees at the time of the session. I will give you a receipt with the billing code, diagnosis code, and amount paid for you to send to your insurance company. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or 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, I

have 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. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

### **CONTACTING ME BY PHONE**

I am often not immediately available by telephone as I am likely working with another patient. Though I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call within 48 hours, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

### **ELECTRONIC COMMUNICATION POLICY**

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

#### Email and Text Message Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email or text me about clinical matters because this is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Email and text messaging should not be used to communicate with me in an emergency situation. I make every effort to respond to emails, texts, and phone calls within 48 hours, except on weekends and holidays. In case of an emergency, please call my phone line at 804-833-3567. If I am not immediately available by phone, please call 911, contact local crisis services or go to the nearest emergency room.

#### Social Media

I do not communicate with, or contact, any of my clients through social media platforms. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant privacy risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to

compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Website: [RichmondNeuropsychology.com](http://RichmondNeuropsychology.com)

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age, there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become common for clients to review their health care provider on various websites. However, mental health professionals cannot respond to such comments because of confidentiality restrictions. It is also generally preferable for clients to discuss their concerns directly with their health care provider. If you have concerns or questions about any aspect of our work together or about any previously posted online reviews of my practice, please let me know so that we can discuss them. I recommend that you do not rate my work with you on any website for several reasons. If you rate my work on a website while you are in treatment with me, it has the potential to affect our therapeutic relationship. If you choose to post an online review about me or another health care provider either while you are in treatment or afterwards, please keep in mind that you may be revealing confidential information about your treatment. Thank you for keeping this policy in mind and for letting me know of any concerns.

Thanks to The Trust Companies for use of this template electronic communication policy. <http://www.trustinsurance.com>.

**CONFIDENTIALITY for ADULT PATIENTS**

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I must or may be legally required to make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

**INFORMED CONSENT and CONTRACT**

**Your signature below indicates that you have read the information in this Consent and Contract document and agree to abide by its terms during our professional relationship.**

**PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

## **CONFIDENTIALITY for CHILD/ADOLESCENT (MINOR) PATIENTS**

### Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

### Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child. If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

### Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and the police.
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in

the past. In this situation, I may be required by law to report the alleged abuse to the appropriate state child-protective agency.

- I am ordered by a court to disclose information.

#### Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

*Example:* If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

*Example:* If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing \_\_\_\_\_, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

#### Disclosure of Minor's Treatment Records to Parents

Although the laws of Virginia may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

#### Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my

records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements. Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of \$300 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

**INFORMED CONSENT for CHILD or ADOLESCENT**

**By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.**

**Minor's Signature\*** \_\_\_\_\_ **Date** \_\_\_\_\_

\* For very young children, the child's signature is not necessary

**INFORMED CONSENT for PARENT/GUARDIAN of MINOR PATIENT**

**Parent/Guardian of Minor Patient:**

**Please initial after each line and sign below, indicating your agreement to respect your child's privacy:**

**I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.** \_\_\_\_\_

**Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.** \_\_\_\_\_

**I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Thanks to Sherry Kraft, Ph.D., clinical psychologist for The Center for Ethical Practice, for use of some the examples and concepts in the child/adolescent portion of this template informed consent. <http://www.centerforethicalpractice.org>.