HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA)

This notice describes how protected health information about clients may be used to carry out treatment, payment, or health care operations, as well as other purposes as permitted or required by law. It also describes a guardian's right to access and control protected information. "Protected Health Information" is information about a client, including demographic information, that may identify the client and relates to the client's past, present, or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Protected health information may be used and disclosed by our office, staff, and/or treatment provider and others outside of this practice who are involved in the care and treatment of any client under our care for the purposes of providing health care services to the client, to pay his/her bill, to support the operation of this practice, and/or any other use required by law.

Treatment: We will use and disclose protected health information to provide, coordinate, and/or manage health care and any related service. This includes the case management of the client's care with a third party as long as we have the client's/guardian's consent unless it is an emergency or we are required by law to report any safety concerns. For example, if we make a referral to another agency, we may use the client's protected health information to facilitate the client's care.

Payment: The client's protected health information will be used, as needed, to obtain payment for services offered by this practice.

Healthcare Operations: We may use or disclose, as needed, protected health information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, training of students, licensing, and/or conducting other business activities. For example, the client's name may be called for his/her appointment in the waiting area and/or we may call the client/caregiver to schedule or confirm an appointment.

We may use or disclose protected health information in the following situations without your authorization. These situations include as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, and workers' compensation. **Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object when required by law. You may revoke this authorization at any time in writing except to the extent that the treatment provider or this practice has taken action in reliance on the use or disclosure indicated in the authorization.**

I acknowledge I have received and understand the HIPAA Notice of Privacy Practices for HILL PSYCHOLOGICAL SERVICES, PLLC and my signature on the submitted HPS STAR Health Referral Form indicates such.

Professional Disclosure Statement and Informed Consent

Psychological and developmental assessments will be conducted by a qualified psychologist and therapy will be conducted by a Licensed Professional Counselor or Licensed Clinical Social Worker. I understand that according to the professional licensing law and professional ethics, these professionals are qualified to perform clinical services. I also understand that a non-physician provider will not prescribe medication. I understand that all providers with *Hill Psychological Services, PLLC* (hereinafter referred to as the *Practice*) are contractors of the *Practice* and thus, the *Practice* is not liable for any of the contractors' actions or services.

I understand that no providers with the *Practice* provide 24-hour crisis counseling. Should a child for whom I have been court-appointed as a medical consenter experience an emergency necessitating immediate mental health attention, I will immediately call 911 or take the child to an emergency room for assistance. I understand the providers, due to their schedules, may not be readily accessible by phone and any message may take up to 48 business hours to return. If the nature of my call can be addressed by the office administrator, I understand that person may be reached before 2 P.M. Monday-Thursday and 1 P.M. on Friday. If I leave a message after 2 P.M. Monday-Thursday and 1 P.M. on Friday, I understand my message will not be returned until the following business day.

I understand all communication will become part of the child's clinical record. Records are the property of the *Practice* and persons acting for or through them. Adult client records are disposed of seven (7) years after the client has stopped receiving services. If the client is a minor, records are disposed of ten 10 years after the client's 18th birthday as required by the provider's licensing board. I understand administrative personnel is necessary for the functioning of the *Practice* and they will have access to the child's information and are bound by the same confidentiality requirements as the child's treatment provider.

I understand that the child's provider will follow the law and seek the appropriate assistance as listed below without my consent. The following are typical but not exhaustive examples of situations and circumstances under which information may be disclosed without my consent:

* A child for whom I have been court-appointed as a medical consenter is a danger to him/herself or someone else;

* In situations of suspected or reported child or elder abuse;

* Disclosure is made of sexual contact with another mental health professional;

* If a judge orders the *Practice* or persons acting for or through it to disclose information; and/or

* The *Practice* and persons acting for or through it is otherwise required by law to disclose the information.

CONSENT TO TREAT

I am requesting that *Hill Psychological Services, PLLC* (hereinafter, referred to as *HPS*) provide psychological testing and/or therapy for a child for whom I have been court-appointed as a medical consenter. I understand records and information collected about the child will be held and released in accordance with state laws regarding confidentiality of such records and information unless as ordered by a judge. I understand state and local laws require that the child's treatment provider report all cases of abuse and neglect of minors and vulnerable adults. I understand that the child's treatment provider is also required by law to report all cases in which there exists a danger to self or others. I understand there are other circumstances in which the law requires the child's treatment provider to disclose confidential information as specified in other forms in this packet of information. By signing this form, I give the child's treatment provider consent to communicate confidential information concerning the child to others in accordance with the law and reasonable professional judgment when such communication appears to be needed to protect the child or others from harm, in response to legal proceedings, or in other proper circumstances. Any disclosure to other sources, such as an attorney, the child's school, or a hospital/physician/psychiatrist to name a few, will only occur with my written consent. I understand I may revoke my consent at any time except to the extent that services have already been provided or that action has already been taken in reliance on this consent. If I do not revoke this consent in writing, it will automatically expire one year after all claims for treatment have been paid. I understand if I default on any payment and do not settle my bill within seven (7) business days of notice provided to me in writing by *HPS* via mail or email, I will be reported to a collection agency, which may negatively impact my credit.

My signature on the submitted *HPS STAR Health Referral Form* is to serve as consent to participate in testing and/or therapy for a child for whom I have been court-appointed as a medical consenter. My signature also confirms I have read and agree with the terms documented on the HIPAA and Professional Disclosures forms.

SPECIAL CONSIDERATIONS FOR TELEPSYCHOLOGY IN RESPONSE TO COVID-19

Due to the current pandemic involving COVID-19, psychological evaluation services will be offered virtually. Please review the considerations below and sign the HPS STAR Health Referral Form if you agree and understand.

Confidentiality

Hill Psychological Services, PLLC's (hereinafter referred to as HPS) psychologist has a legal and ethical responsibility to make best efforts to protect all telepsychology communications. However, the nature of electronic communications technologies is such that it is impossible to guarantee communications will be kept confidential or that other people may not gain access to such communications. Certain measures will be taken to help keep information private and confidential, such as use of a HIPAA-compliant platform, updated encryption methods, firewalls, and back-up systems. The client(s) should also take reasonable steps to ensure the security of communications, such as the client(s) being in a private area free of interruptions and use of a secure internet connection rather than public/free Wi-Fi, a device that is password-protected, and headphones. The extent of and exceptions to confidentiality outlined in the *HPS* Informed Consent still apply in telepsychology.

Records

The telepsychology sessions will not be recorded in any way. Records of the telepsychology session(s) will be documented and maintained in the same way of the in-person session(s) in accordance with *HPS* policies.

Specific Considerations for Testing

- To protect testing materials, taking screen shots of, recording, or allowing others to see the screen during testing is strictly prohibited. *HPS* will not record or screen shot the telepsychology session(s).
- The client should be in a private space free of distractions/unnecessary interruptions (i.e. cell phone, other residential members, etc.) in a well-lit room, preferably in an area in which one can comfortably write.
- The client will need to use an electronic device with a video camera for the telepsychology session, preferably a PC/laptop so the testing stimuli can be projected at the correct size. Please know, the psychologist will not be alerted if the child exits the telehealth session by opening other programs. If using a tablet, it must have a full-sized screen; a cell phone/mini tablet should **NOT** be used, as it will not provide a large enough screen for testing stimuli.
- The client will need access to paper, a hard surface, and a pencil with an eraser.
- It is recommended the client use headphones or earbuds for enhanced privacy and sound quality.

- Just as during an in-person evaluation with *HPS*, the caregiver(s) is expected to be present during the telehealth session for the caregiver interview unless this has been conducted prior to the child's telehealth session.
- Completion of the evaluation may take more than one telehealth session.
- Any caregiver and/or child online assessment questionnaires emailed to the caregiver prior to the telehealth session(s) should be completed before the initial telehealth session appointment.
- An individual with technological knowledge will need to initially join the telehealth session from the emailed link and ensure the technology is working and set up properly.
- An approved caregiver should remain close by during the evaluation, as it is good practice to periodically check on the child for safety and technological purposes. Additionally, should a child react poorly to the line of questioning/task, the child should have support close by, if needed.
- An approved caregiver should remain available by phone to be directly contacted by this provider in case of an emergency.
- If the client is having an emergency, immediately call 911 or go to the nearest emergency room. Please notify *HPS* after appropriate emergency services have been obtained.
- The provider may determine that due to certain, unforeseen circumstances, telepsychology is not an appropriate option and the psychological evaluation should occur once an in-person evaluation is possible.

Your signature on the submitted **HPS STAR Health Referral Form** indicates agreement with the terms and conditions in this form.

INFORMED CONSENT FOR TELEPSYCHOLOGY

Due to the current pandemic involving COVID-19, psychological evaluation services will be offered virtually. Please review the considerations below and sign if you agree and understand. Please let me know if you have any questions.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychological services remotely using telecommunications technologies, such as video conferencing. One of the benefits of telepsychology is the ability to continue services without being in the same physical location, which can be helpful in ensuring continuity of care when unable to meet in person. Although there are benefits of telepsychology, it involves some additional risks, as well, including the following:

- Risks to confidentiality. There is potential for others to overhear communications. Recommendations to address this include the client being in a private area free of interruptions and use of a secure internet connection rather than public/free Wi-Fi, a device that is password-protected, and headphones. *Hill Psychological Services, PLLC* (*HPS*) will take reasonable steps to help protect client privacy, including using a HIPAA-compliant technology platform. Please know, despite this, other people might be able to gain access to private conversations or stored data could be accessed by unauthorized people or companies.

- Issues related to technology. It is possible for technology issues to affect the process, such as disruption of the video/audio feed. In an effort to prevent this, it is recommended other residential members not use services requiring substantial bandwidth during the test session. If technology interruptions occur, testing results from that particular measure may not be usable; steps to rectify this issue will be discussed. If the session is interrupted and the client is not having an emergency, disconnect from the session and *HPS* will send a link to the original email address on file to reestablish contact via the telepsychology platform. If contact is not made within two (2) minutes, the client should call *HPS* at the number provided.

- Efficacy. Most available research shows psychological evaluation measures involving nonmotor tasks/skills administered via telepsychology are minimally affected by this method and maintain clinically acceptable levels of validity and reliability. However, the specific psychological evaluation measures utilized in this evaluation may not have been researched for use via telepsychology. *HPS* will take this into account when making clinical decisions and recommendations and appropriately document such in the resulting psychological evaluation report.

Confidentiality

HPS' psychologist has a legal and ethical responsibility to make best efforts to protect all telepsychology communications. However, the nature of electronic communications technologies is such that it is impossible to guarantee communications will be kept confidential or that other people may not gain access to such communications. Certain measures will be taken to help keep information private and confidential, such as use of a HIPAA-compliant platform, updated encryption

methods, firewalls, and back-up systems. The client(s) should also take reasonable steps to ensure the security of communications, such as the client(s) being in a private area free of interruptions and use of a secure internet connection rather than public/free Wi-Fi, a device that is password-protected, and headphones. The extent of and exceptions to confidentiality outlined in the *HPS* Informed Consent still apply in telepsychology.

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Records

The telepsychology sessions will not be recorded in any way. Records of the telepsychology session(s) will be documented and maintained in the same way of the in-person session(s) in accordance with *HPS* policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent agreed upon at the outset of services with *HPS* and does not amend any of the terms of that agreement. Your signature on the submitted **HPS STAR Health Referral Form** indicates agreement with the terms and conditions in this form.