Neuropsychological Evaluation and Therapeutic Center of Austin, LLC
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(512) 540-4767
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www.NeatCenterAustin.com

Neuropsychological Evaluation Intake Packet

Information and Consents

Thank you for selecting the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC, to help meet the needs of you, your family member or your child. We know you have many options to choose from and appreciate your having selected us to assist you with neuropsychological evaluation, assessment and/or treatment.

The attached packet of information will allow you time to gather information prior to your first appointment that will be helpful in the evaluation, assessment and treatment of the patient being assessed.

Thank you for the trust that you are placing in us to assist you. We understand that some of these forms may be challenging, time consuming and, in places, redundant. We want you to know that the more information that we have, the better able we will be to assist you. If at any time in this process you have any questions, please contact us. You can reach the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC, during normal business hours, at (512) 540-4767, via the website at www.NeatCenterAustin.com or if you are a patient of Dr. Reynolds, you can reach her directly at DrJenniferReynolds@NeatCenterAustin.com.

We are honored that you have chosen us for your neuropsychological needs and we greatly look forward to meeting and working with you.

What Information Should I Bring to the Evaluation?

Thank you for choosing us to conduct the comprehensive evaluation of you, your family member or your child. For us to provide you with the most accurate and complete evaluation, we must have access to the medical and psychological history of the patient. Without access to this information, the diagnostic process is significantly restricted.

The following information needs to be provided, prior to the first actual testing session in order for us to be better able to select appropriate testing options for the assessment session(s).

Releases are included in this packet to aid in the gathering of this information.

The following intake forms are included in this packet:

☐ Consent and Agreement to Neuropsychological Testing and Evaluation – to be **Signed**

☐ Informed Consent for Psychological Services – to be **Signed**

☐ Agreement Regarding Office Policies, Procedures and Fees – to be **Signed**

☐ Authorization to Disclose Health Information to Family Members and Friends – to be **Signed**

☐ HIPPA Notice and Consent – to be **Signed**

☐ Custody Records and Power of Attorney - **If applicable,** we require a copy of any custody agreement or power of attorney (POA) decree in order to document who has legal rights regarding the patient and/or minor child

In addition, the following separate form must be completed and returned to us no less than 24 hours before your initial appointment:

☐ Medical and Psychological History

If you wish us to contact other agencies or individuals, you will need to fill out and sign the following separate form for each such agency and/or individual:

☐ Request/Authorization to Release Confidential Medical & Mental Health Records and Information – **Signed** (this form is provided upon request for you to complete, sign and return to us if you wish us to be able to contact and speak with other agencies or individuals regarding the patient's prior medical and mental health history and/or treatment)

We request that, to the best of your ability, you are able to provide the following medical records (if you do not have the physical medical records but know the information being asked, you can provide it on the separate Medical and Psychological History form):

- Records of last regular visit with primary physician/pediatrician.
- Records of visits with specialists (ENT, gastroenterologist, orthopedist, developmental pediatrician, optometrist, audiologist, etc.).
- Current vision and hearing status/evaluations.

- Records of current and past medications (both prescription and over-the-counter plus “supplements” and “natural” substances).
- Records of illnesses, surgeries, accidents and hospitalizations.

We always appreciate the effort it takes to organize, track and provide all this information. We will be happy to make copies at the office of any materials that you bring with you.

If you have any questions regarding the evaluation process, or the information contained in this Information and Consents packet, please contact us at (512) 540-4767.

Thank you and we look forward to seeing you soon!

Consent and Agreement for Neuropsychological Testing and Evaluation

Patient Name: _____ Patient Phone: (____)-____-_____

Patient Address: _____ City:_____State:_____Zip:_____

Neuropsychological Evaluation and Therapeutic Center of Austin, LLC will provide services specifically designed to help you (and/or your family member or minor child), or otherwise provide you with referrals to other professionals. Our clinical neuropsychological and behavioral services consist primarily of individual assessments (neuropsychological, psychological and behavioral evaluations), in-home and in-school consultation and observations, long and short-term therapy, and short-term consultations with individuals, parents, educators and other related professionals.

I,_____ (patient name), agree to allow the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Jennifer Reynolds to perform the following services:

___ Neuropsychological testing, assessment and/or evaluation.

___ Report writing.

___ Other (describe): IEP representative, legal witness, expert witness, psychoanalysis and/or other therapy as needed and/or requested.

I understand that these services may include direct, face-to-face contact, interviewing, assessment, testing, evaluation and therapeutic intervention. They may also include Dr. Reynolds' time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting results, and any other activities to support these services (IEP meetings, court proceedings, etc.).

If information is requested from third parties, the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Reynolds cannot be responsible for their response, or lack of response, to requests to participate in the evaluation process. Dr. Reynolds will, at her sole discretion, determine if additional attempts will be made to solicit input from any third party(ies).

I understand that this evaluation is to be done for the purpose(s) of:

1. Diagnostic determination.
2. Recommendations for educational, social, emotional, language and behavioral planning.

I also understand that the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC will adhere to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining my privacy will be carried out in accordance with the rules and guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Family Educational Rights and Privacy Act (FERPA) and the Texas State Board of Examiners of Psychologists, and are governed by the laws of the State of Texas.

2. Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and

population have been established.) These tests will be given and scored according to the instructions in the tests' manuals so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.

3. Tests and test results will be kept confidential and in a safe place.

I agree to help as much as I can by supplying full answers, making an honest effort and working as best I can to make sure that the findings are accurate.

_____

Patient Name

_____

Parent or Guardian Name (if applicable)

_____ _____

Patient Signature (Parent/Guardian if applicable) Date

Informed Consent for Psychological Services

I hereby voluntarily apply for and consent to behavioral and/or neuropsychological services to be provided by the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Jennifer Reynolds. This consent applies to me or the patient named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand that the potential benefits of undergoing these services may include obtaining a professional opinion, reduction of my symptoms, and an increased understanding of myself, my family and/or my child. I understand that potential risks may include predictive validity of assessments (when applicable), possible disagreement with the opinions offered to me, and possible emotional distress when addressing my situation. I understand that alternative procedures include services provided by another professional. I understand that I may ask for a referral to another professional if I am not satisfied with the progress of my treatment. I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions – some of which are listed as follows: (1) where abuse or harmful neglect of children, the elderly, or disabled or incompetent individuals is known or reasonably suspected; (2) where the validity of a will of a former patient is contested; (3) where such information is necessary for the professional to defend against a malpractice action brought by the client; (4) where such information is necessary for the professional/limited liability company to pursue payment for services rendered; (5) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the professional; (7) where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue; (8) pursuant to a court order, open Texas Department of Family and Child Services investigation, National Security Investigation, or otherwise allowed or compelled under the law; and (9) where the client is examined pursuant to a court order. I hold Dr. Jennifer Reynolds and the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC harmless for releasing information under the above conditions.

This agreement concerns:

_____

Patient Name

_____

Parent or Guardian Name (if applicable)

_____ _____

Signature (Patient or Parent/Guardian) Date

Agreement Regarding Office Policies, Procedures and Fees

This Agreement Regarding Office Policies, Procedures and Fees (this "Agreement"), dated as of the date set forth on the signature page, is by and between the undersigned patient (and as applicable, his or her parent or guardian) and the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC, with Dr. Jennifer Reynolds as an intended third-party beneficiary of this Agreement. The parties agree as follows:

APPOINTMENTS

Except for rare emergencies, Dr. Jennifer Reynolds and any other staff of the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC will see you (or your family member or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you contact the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and give us as much notice as possible to cancel or reschedule.

This will allow us to offer your time to another person. You may be charged the standard hourly rate (see below) for appointments unkept or cancelled with less than 48 hours advance notice.

PREPARATION FOR TESTING

It is important that individuals be able to perform at their best during testing and assessment sessions. Please let the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC staff know before you arrive (and as soon as possible) if the individual to be tested is not feeling well or is taking any prescribed or over-the-counter medications that have not been disclosed in advance. In such cases, the testing session may need to be rescheduled. Individuals to be tested should be well rested and should bring snacks for breaks during the testing session. Because of the variety of dietary restrictions, the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC cannot offer any food or snacks to patients. Assessment procedure time can vary from 3 to 9 hours depending on the specific assessments given and/or the developmental level of the individual being tested. During testing, we will take breaks as needed; however, if testing is expected to go over 4 hours, we may recommend that testing take place over the course of 2 or 3 days (back to back) so as to avoid any testing fatigue that might occur to the patient. Parents and guardians are allowed to leave while we conduct testing, but they must be available by phone and need to be no further than 15 minutes away in case an emergency should arise. However, parents and guardians should plan to remain in the clinic during testing sessions if it is medically, physically or psychologically warranted; and/or Dr. Jennifer Reynolds thinks that their remaining on site will be of benefit to the patient assessment procedure(s).

CONFIDENTIALITY, RECORDS AND RELEASE OF INFORMATION

Psychological services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC with written authorization

to release specified information to specific individuals, or under other conditions and as mandated by Texas and federal law and the professional codes of conduct/ethics. These exceptions are discussed below:

1. **To Protect the Patient or Others from Harm**. If Dr. Jennifer Reynolds has reason to suspect that a minor, elderly or disabled person is being abused, she is required by law to immediately report this (and any additional information upon request) to the appropriate state agency. If she believes that a client and/or patient is threatening serious harm to himself/herself or others, she is required to take protective actions which could include notifying the police, an intended victim, a minor's parents or others who could provide protection (for example, by seeking appropriate hospitalization).

2. **Professional Consultations**. Neuropsychologists routinely consult about cases with other professionals. In so doing, Dr. Jennifer Reynolds will make every effort to avoid revealing the identity of her clients/patients, and any consulting professionals are also required to refrain from disclosing any information that Dr. Reynolds reveals to them. Unless you object, Dr. Reynolds does not typically tell clients/patients about these consultations; however, these consultations will be so noted in your private health information (PHI). If you want Dr. Reynolds to talk with or release specific PHI to other professionals with whom you are working, or who you think could provide valuable information to help assist Dr. Reynolds, you will first need to sign an authorization that specifies what information can be released and with whom it can be shared.

3. **Records**. Dr. Jennifer Reynolds will review all testing results during the feedback session, and if requested by you, will offer you opportunities to review overall testing data with her. You will receive a written report that summarizes her findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and/or consultations conducted as a part of a comprehensive individual evaluation. Upon your request, Dr. Reynolds is happy to provide you with a written summary of her impressions from other meetings, consultations or observations as well. She will forward copies of any reports or written summaries to others only with specific written consent from you. Because of the proprietary nature of testing materials, Dr. Reynolds will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

4. **Legal Proceedings**. If you are involved in a court proceeding and a request is made for information concerning assessment, evaluation or therapeutic services you or your child/ward receive(d) from the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and/or Dr. Jennifer Reynolds, such information that is protected by the psychologist-patient privilege law might be limited in confidentiality. There is limited protection for information conveyed to others consulting with the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Reynolds. Under the law, Dr. Reynolds cannot provide any information without your written authorization except in the case(s) of open Texas Department of Family and Child Services investigations, National Security Investigations or court order. In those cases, Dr. Reynolds will use reasonable efforts to reveal only the minimal legally acceptable amount of information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order Dr.

Reynolds to disclose information. Also, if a client/patient files a complaint or lawsuit against anyone affiliated with Dr. Reynolds and/or the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and/or any of its employees, we may disclose any and all relevant information regarding that client/patient that we deem necessary in order to defend ourselves.

5. **Work with Minor Children and/or Person(s) Under Power of Attorney**. If a client/patient is under eighteen (18) years of age, or under legal guardianship by power of attorney, the law may provide parents and guardians with the right to examine the patient's records. Privacy, however, is often crucial to successful progress in treatment and valid evaluation results. If, in the course of an evaluation or consultation, a minor child or guardianship individual reveals information that he or she does not want shared with his or her parents or guardian, Dr. Jennifer Reynolds will usually not reveal such information unless she believes that there is a high risk that the patient will seriously harm himself/herself or others, in which case we will notify him or her of Dr. Reynolds' intent to notify his/her parents or legal guardian(s).

6. **Health Care Insurance, MEDICAID and MEDICARE**. Neither the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC nor Dr. Jennifer Reynolds files insurance claims at this time. However, we will provide you with statements that you may submit to your insurance carrier for reimbursement, or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of-network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, or copies of your (if you are the patient), your dependent adult's or your child's entire clinical record. In such situations, Dr.

   Reynolds will use commercially reasonable efforts to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, we 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. Dr. Reynolds will provide you with a copy of any report or form that she submits upon your request. By signing this Agreement, you agree that we can provide requested information to your carrier if/when you choose to file a claim for out of network reimbursement for any services that we have provided to you, your child or your dependent adult. Also, be advised that many insurance plans do not pay for neuropsychological, psychological and/or behavioral testing; or they significantly limit the amount of coverage they provide for this kind of service. This is also true for testing and therapy services for Autism Spectrum Disorders (or other services judged to be primarily educational in nature).

FEE SCHEDULE

Our hourly fee is $175 per 50-minute hour for consultations, meetings, and psychotherapy with Dr. Jennifer Reynolds and this is the minimum fee per session. If a session lasts longer than one hour, we bill the additional session time in quarter-hour increments. We charge this same fee on a pro-rated basis for telephone calls longer than fifteen (15) minutes. Travel and daily rates for Dr. Reynolds are arranged via individual contract agreement.

Payment in full is due at the end of each appointment, except for testing, or within fifteen (15) days of receipt of monthly service invoices. For individual testing, assessment and evaluation, the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC charges a flat fee for evaluations of:

- $3,800 For a standard neuropsychological diagnostic evaluation (depression, anxiety, obsessive compulsive disorder, PTSD, bipolar disorder, basic memory functioning, etc.).

- $5,800 (+) for a comprehensive Neurocognitive Evaluation (e.g., a neuropsychological testing and cognitive assessment for forensic purposes, Alzheimer's, traumatic brain injury, learning disorders, pervasive developmental disorders, etc.).

A laborious and extensive amount of time is committed and required to provide this kind of service; therefore, we ask that 50% of the fee be paid as a deposit at the time of the making the first appointment (making arrangements for the testing session) with the remaining balance due and payable prior to the time of meeting with Dr. Reynolds to review the report and address any questions. This fee/evaluation typically includes (and solely at the discretion of Dr. Reynolds) a review of records that you provide; an initial one to two hour interview with the referral source (usually a spouse, parent or guardian(in the case of a minor child) or adult under power of attorney); consultations with other professionals working with you and/or the patient; direct observation, testing, assessment scoring and evaluation and preparation of one comprehensive written report (usually between 30-60 pages in length); and a 1-hour feedback session and a follow-up phone call, if deemed necessary.

Additional services such as any other consultative or psychotherapeutic sessions, follow-up consultations with you or other parties (such as teachers, physicians or other relevant professionals), school or home observations (that may or may not be part of a more comprehensive evaluation) or preparation of any additional reports, will be charged on an hourly basis for the hourly fee noted above (including, but not limited to, travel and preparation time for Individualized Education Placement and 504 meetings. Forensic proceedings, expert witness testimony, mitigation, etc. is charged at a rate of $600.00 an hour (plus travel fees and expenses).

We accept payment in the form of cash, check, bank debit card or credit card (American Express, MasterCard or Visa only). In the unlikely event that you fail to pay for services rendered and your account is more than thirty (30) days past due, we may enlist the services of

other persons or agencies to collect past-due amounts, and you will also be charged for any expenses so incurred.

CREDIT CARD INFORMATION

The Neuropsychological Evaluation and Therapeutic Center of Austin, LLC requires that a credit card, or bank debit card, be on record in the patient's confidential file to be charged by us (i) if you fail to pay for patient assessment or evaluation protocols, therapy session(s) and/or missed sessions as due, or (ii) you otherwise authorize us to charge the card in connection with treatment by us.

You agree that the following credit/debit card account (i) names you as an authorized user, (ii) may be retained on file by us and (iii) may be billed by us in connection with treatment by us and as otherwise set forth in this Agreement:

Credit Card Number: _____

Expiration Date: _____

Security (CVV) Code: _____

Billing Zip Code: _____

By signing this Agreement, you agree to all the terms included herein, including the above-mentioned fees.

_____

Patient Name (Parent or Guardian Name if applicable)

_____

Patient Signature (Parent/Guardian if applicable)

_____ _____

Date

Authorization to Disclose Health Information to Family Members and Friends

Patient Name: _____ Date of Birth: _____/ _____/ _____

I hereby authorize the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Jennifer Reynolds to release the patient's protected health information (PHI), as set forth in this Authorization, to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PHI may include information/documents regarding psychological treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; and account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.
I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and its implementing regulations, govern the terms of this Authorization. I understand that I have the right to revoke this Authorization at any time prior to the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC's and/or Dr. Jennifer Reynolds' compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization are set forth in the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC's notice of privacy practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer" at the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC. I understand that I am not required to authorize any other person to receive my PHI and that the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Jennifer Reynolds may not condition treatment on my execution of this Authorization. I understand that the PHI used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient(s) listed above and, in that case, will no longer be protected by HIPPAA. This Authorization automatically expires on the earlier of when the patient is no longer a patient of the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC or you have revoked this Authorization.

(Check One)

☐ I DO

☐ I DO NOT

give permission to the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Jennifer Reynolds to leave information on my answering machine and/or with my family members regarding treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

Other than those releases authorized by HIPAA, PHI will only be released to persons (if any) listed on this Authorization.
If you choose not to authorize any family members or friends for disclosure of PHI, the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC and Dr. Jennifer Reynolds will not be able to release any information, including appointment or patient billing questions, to anyone other than the patient and/or the patient's parent/guardian.

_____

Patient Name (Parent or Guardian if applicable)

_____ _____

Signature (Patient or Parent/Guardian) Date

HIPAA Notice and Consent

PROFESSIONAL RECORDS

You should be aware that, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC keeps each patient's protected health information (PHI) in two sets of professional records. One set constitutes the Clinical Record and it includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative or psychotherapeutic goals; progress towards those goals; a medical, developmental, educational and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Except in unusual circumstances that involve danger to the patient or others, or where the records make reference to another person (unless such other person is a health care provider) and we believe that access to the patient's records is reasonably likely to cause substantial harm to such other person, you or your legal representative may examine and/or receive a copy of your Clinical Record if you request it in writing. We have thirty (30) days from the date that the written request is received by us to comply. Because these are professional records, keep in mind that they can be misinterpreted and/or upsetting to untrained readers and/or may contain information that is protected by federal copyright laws. For this reason, we recommend that you initially review them in Dr. Jennifer Reynolds' presence, or have them forwarded to another mental health professional so that you can discuss the contents. In most situations and with certain exceptions, we can charge a fee for copying (and for certain other expenses) plus postage as regulated under Texas law. If we refuse your request for access to your records, you have a right of review (except for information provided to us confidentially by others) which Dr. Reynolds will discuss with you upon request.

In addition, Dr. Reynolds also keeps a set of Personal Notes for her patients/clients to whom she provides even brief or consultative services to. These notes are for her own use and are designed to assist her in providing you with the best treatment. While the contents of Personal Notes vary from patient to patient (client to client), they often include references to conversations, neuropsychological and psychological testing recording forms, Dr. Reynolds' analysis of those conversations, and the effects of these conversations on her patients/clients. They also may contain particularly sensitive information revealed to her that is not required to be included in the Clinical Record (and information supplied to her confidentially by others).

These Personal Notes are kept separate from the Clinical Record. Personal Notes are not available to you and cannot be sent to anyone else, including insurance companies. Your signature below waives all rights, now and in the future, to accessing these records. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights regarding your Clinical Record and disclosures of protected health information (PHI). These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is

disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this HIPAA Notice and Consent and our privacy policies and procedures. We are happy to discuss any of these rights with you.

CONTACTING US

Given Dr. Reynolds' many professional commitments, she is often not imme diately available by telephone. If you need to leave her a confidential message you can do so by calling our office at (512) 540-4767 or emailing her at DrJenniferReynolds@NeatCenterAustin.com, and she will make every effort to return your call or email promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please leave times when you will be available. Because of the nature of the services Dr. Reynolds usually provides, she **does not** provide on-call coverage 24 hours per day, 7 days per week. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room. Please be advised that if you communicate with Dr. Reynolds and/or the Neuropsychological Evaluation and Therapeutic Center of Austin, LLC or its staff, via email or text messaging, that although commercially reasonable measures are taken to safeguard your information, due to the nature of electronic communications, your confidentiality cannot be guaranteed.

CONSENT

Your signature(s) below indicates that you have read the information in this HIPAA Notice and Consent, agree to be bound by its terms, and that you have received all mandated HIPAA notices and/or have been offered a copy and declined.

_____

Patient Name (Parent or Guardian if applicable)

_____ _____

Signature (Patient or Parent/Guardian) Date