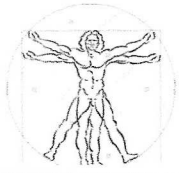

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Comprehensive Psychological Services

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

_____

Phone: (_____)_____ Email: _____

Insurance Provider: _____

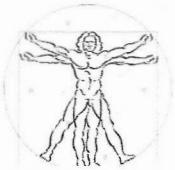
Reason for Seeking Treatment/Evaluation at this time: _____

_____

_____

_____

_____



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CONSENT AND AGREEMENT FOR PSYCHOLOGICAL TESTING AND EVALUATION

I,_____, agree to allow the evaluator named below to perform the following services:

Neuropsychological testing, assessment, or evaluation Report writing
Consultation with lawyers Testimony in court
Deposition (that is, written testimony given to a court, but not made in open court)
Other (describe):_____

This agreement concerns myself or : _____

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the evaluator's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, and any other activities to support these services. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

I understand that the fee for this (these) service(s) is at **$225.00** per hour unless otherwise agreed upon. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment of these services.

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

1. _____

2. _____

I also understand the evaluator agrees 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 accord with the rules and guidelines of the American Psychological Association, the Health Insurance Portability and Accountability Act (HIPAA) and other professional organizations.

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 in a safe place.

I understand that a psychological evaluation is an interactive process between the client and evaluator. It is meant to promote understanding and treatment planning. Sometimes the process can be emotionally painful and other times it may be fulfilling. I have the right to choose my evaluator or to refuse services. If I choose to end services for any reason I understand Nuance Neuropsychology LLC will make a list of qualified evaluators available to me. I should question the rationale of treatment if it is unclear to you. While the evaluator has every expectation of helping, they cannot guarantee any specific outcome.

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. My signature below confirms that I have read the above and agree to its terms and also serves as an acknowledgement that I have received the HIPAA Notice Form described above.

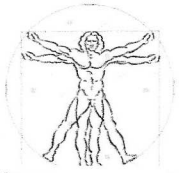
_____ _____

Signature of client (or parent/guardian) Date

I, the evaluator, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of evaluator Date



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NEUROPSYCHOLOGICAL INTAKE FORM

Notice to Patient: This personal history form is intended to help us gather all the information we need to help you. Everything is confidential and will not be released without your permission. Don't worry if you can't answer some of the questions, or if some do not apply to you. Just fill in the blanks as completely as you can and we will review the information with you during the initial consultation. PLEASE PRINT OR WRITE LEGIBLY. Thank you.

Today's Date:_____

Name:_____

(First) (Middle Initial) (Last)

Date of Birth:_____ Age:_____ Gender: ☐Female ☐Male
Writing hand: ☐Right ☐Left ☐Ambidextrous Ethnicity:_____
Highest Level of Education:_____
Is English your first language? ☐Yes ☐No If not, what is your first language?_____
Who referred you for this evaluation?_____
Have you ever had neuropsychological or psychological testing before? ☐Yes ☐No

If yes, by whom? _____ When? _____ Why? _____

HISTORY OF PRESENTING PROBLEM

Why are you being seen for a neuropsychological evaluation (e.g. I had a stroke, I got in a car accident and sustained a head injury; Family members say I have memory problems; etc.)?_____

_____

_____

_____

_____

Date problem(s) began (estimate):_____
Course: ☐Getting Better ☐Getting Worse ☐Staying the Same

CURRENT PROBLEMS

Please check ALL Categories that apply. Please identify the issues affecting you under each Category Section.

☐Attention

☐Frequently missing details, making careless errors	☐Difficulty paying attention for long periods of time
☐Easily distracted	☐Difficulty following instructions

☐**Processing speed**	
☐Difficulty thinking quickly	☐Feeling as though most people talk too fast
☐Taking longer to complete tasks than before	☐Frequently asking people to repeat themselves (not due to hearing difficulty)

☐**Learning and Memory**	
☐Difficulty remembering recent events, names, faces, the date, etc.	☐Difficulty learning and remembering new information
☐Loss of long-term memories	☐Forgetting to take medication

☐**Executive Functioning**	
☐Acting before thinking	☐Difficulty problem solving, or making bad decision
☐Difficulty following multi-step direction	☐Difficulty planning and organizing

☐**Nonverbal/visual spatial skills**	
☐Getting lost in familiar locations	☐Problems Driving
☐Inappropriate use of objects (i.e. remote as hat)	☐Right-Left or directional disorientation

☐**Speech & Language**	
☐The feeling that a word is on the tip of your tongue	☐Mislabeling items (ex. Clock vs. watch)
☐Reduced speech volume	☐Difficulty understanding others or following conversations

☐**Motor/Coordination**	
☐Difficulty buttoning a shirt	☐Difficulty opening medicine bottles
☐Difficulty with walking or balance/ recent falls	☐Shakiness/Tremor

☐**Sensory**	
☐Reduced sense of smell	☐Tingling sensation
☐Loss of feeling in part of your body	☐Difficulty perceiving your bodies location in space

☐**Physical Problems**	
☐Frequent headaches	☐Bowel or Bladder Incontinence
☐Dizziness, nausea, vomiting	☐Shortness of Breath
☐Sleep Disturbance/ Weight Change	☐Pain

☐**Mood & Behavior**	
☐Increased irritability	☐Hallucinations (visual, auditory, or olfactory)
☐Increased Sadness/ Crying for unknown reasons	☐Increase nervousness, suspiciousness, etc.

☐Thoughts of harming yourself or taking your life	☐Discomfort in Social Situations
☐ Recent Life Stressors	
☐Change in job	☐Change in marital status
☐Death of loved one	☐Financial or legal problem
☐Moved to a new location	☐Taking care of aging or ill loved one

Please rate your overall stress level: □ Very Low □ Low □ Average □ High □ Very High

What is the greatest source of your stress at this time?_____

ACTIVITIES OF DAILY LIVING

Do you drive? □ Yes □ No
Who does the cooking at home? □ Myself □ Another Person

Do you manage your own finances? □ Yes □ No
Do you manage your own medications? □ Yes □ No

MEDICAL HISTORY

Please check the box to indicate any problems you have been identified as having and note (estimate) the year of diagnosis.

Neurologic	Date	Endocrine	Date
□ Brain Injury		□ Diabetes	
□ Brain Aneurysm		□ Hypoglycemia	
□ Migraines		□ Hypothyroidism	
□ Movement Disorder		□ Hyperthyroidism (e.g., Graves)	
□ Brain or Spinal Tumor		□ Parathyroid Disorder	
□ Stroke		□ Adrenal Gland Disorder (e.g., Addisons)	
□ Seizures		□ Kidney Disorder	
□ Dementia		□ Cushing's Syndrome	
□ Narcolepsy		□ Low Testosterone	
□ Sleep Disorder		□ Menopause	
Cardiovascular		**Ear, Nose, & Throat**	
□ High Blood Pressure		□ Chronic Ear Infections	
□ High Cholesterol		□ Swallowing Disorder	
□ Heart Disease		□ Macular Degeneration	
□ Arteriosclerosis		□ Cataracts or Glaucoma	
□ Blood Disease (e.g., anemia)		□ Dizziness (e.g., vertigo, BPPV)	
Genital-Urinary/ Gastro-Intestinal		**Muscular-Skeletal**	
□ Bowel or Bladder Incontinence		□ Amputation	
□ Colon Disease (e.g., Crohn's, IBS)		□ Arthritis	
□ Regular Urinary Tract Infections		□ Degenerative Joint Disease	
□ Gastroesophageal Reflux Disease		□ Osteoporosis	
□ Pancreatitis		□ Fibromyalgia	

□ Liver Disease (e.g., hepatitis)		□ Chronic Fatigue Syndrome	
Oncology		**Genetic**	
□ Type & Site of cancer: _____		□ Type (e.g., Fragile X, Down Syndrome, Mitochondrial Disease) _____	
Mental Health		**Other:**	
□ Anxiety Disorder			
□ Mood Disorder (e.g., Depression, Bipolar)			
□ Psychotic Disorder (e.g., Schizophrenia)			
□ Substance Use Disorder			

Have you had any blood work or imaging (e.g., CT, MRI, X-Ray) done in the past year?

□ Yes □ No

If yes, what did you have done: _____

Please list ALL medications you are currently taking

Medication	Dose	How often do you take it	Reason

Have you EVER received treatment for depression, anxiety, or any other emotional difficulty? Check all that apply:

□ Never received mental health treatment
□ Outpatient counseling
□ Inpatient psychiatric services
□ Pharmacological treatment (antidepressants, anti-anxiety medications, etc.)

Are you CURRENTLY receiving treatment for depression, anxiety, or other emotional difficulty? □Yes □No

FAMILY MEDICAL HISTORY

Please check any diagnoses that your family members (blood relatives) have.

Medical Condition	Mother	Father	Mother's Mother	Mother's Father	Father's Father	Father's Mother	Sibling	Other
Dementia								
Seizures								
Movement Disorder (e.g., Parkinson's)								
Multiple Sclerosis								
Migraines								

Stroke								
Diabetes								
Hypertension								
Cancer								
Hyper-/hypothyroidism								
Genetic Disorder								
Learning Disability								
ADHD								
Intellectual Impairment/Disability								
Other:_____								

SOCIAL HISTORY

Where were you born? _____

Relationship Status: □ Single □ Married (Years Married: _____) □ Divorced □Widowed □ Other

Do you have Children: □ Yes □ No If yes, please list their ages: _____

Currently living in: □ House □ Condo/Apartment

□Assisted Living Facility □ Nursing Home

OCCUPATIONAL/EDUCATION HISTORY

Level of Education	Name of School/Degree	Year Graduated	Typical Grades or GPA
High School			
College or Vocational			
Graduate School			
Other			

Did you have any academic difficulty? □ Yes □ No If yes, please answer the next 2 questions.

1. Did you repeat a grade? □ Yes □ No

2. Were you diagnosed with a learning Disability? □ Yes □ No

Employment Status: □ Employed □ Unemployed □ Retired □ Disabled If you are currently employed, please answer the next 3 questions.

1. Where do you work?_____

2. How long have you worked there?_____ 3. What's your Job title?_____

Did you serve in the Military? □ Yes □ No
If yes, Branch:_____ Years Served:_____ MOS:_____

Discharge Rank:_____ Type of Discharge:_____
Deployment History:_____

SUBSTANCE USE

Tobacco Use	□ Never used □ Currently use □ Quit (When did you quit?_____)		Type and amount per day:
Alcohol Use	□ Past □ Present □ Never	How often: □ Occasional/Rare □ Weekly □ Daily	Estimated # of drinks per week:_____
	Are you or others you know concerned about your alcohol use? □ Yes □ No Have you ever received treatment for alcoholism or alcohol abuse? □ Yes □ No If yes, please list the date(s) and location(s) of your treatment:		
Recreational Drug Use (Includes prescription drug abuse)	□ Past □ Present □ Never	Have you ever received treatment for drug abuse or addiction? □ Yes □ No If yes, please list the date(s) and location(s) of your treatment:	
Caffeine Use	□ Past □ Present □ Never	Estimated number of 8-oz. cups of caffeinated beverages per day: _____	

LEGAL HISTORY

Do you have any legal history (prior court cases, arrests, etc.)? If yes, please describe:_____

_____

Is this case involved in litigation, or do you intend to pursue litigation in the future? □ Yes □ No

Have you granted anyone Power of Attorney (POA)? □ Yes □ No If so, who? _____

Thank you for completing this form.

Emergency Contact Form

Ensure that the information on this form is validated and updated periodically.

Personal Information | **Date when this form was filled or updated:**

Name: _____

Work Address: _____ _____

_____

_____

City State Zip code

Home Address: _____ _____

_____

_____

City State Zip code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail (Home): _____ E-mail (Work): _____

Primary person to be notified in case of an emergency:

Name: _____

Relationship: Relative _____ Friend _____ Other _____

Home Address: _____

Street Address City State Zip code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Secondary person to be notified in case of an emergency:

Name: _____

Relationship: Relative _____ Friend _____ Other _____

Home Address: _____

Street Address City State Zip code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Insurance Information:
Provider:_____ Contact person: _____ Reference No: _____ Phone: _____
List down any medications you take routinely and provide details:
Details of any medical/mobility/mental health conditions that affect you currently or in the recent past.
List any allergies that affect you & provide details:
Any other information that emergency personnel should be aware of:

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used by _____ and emergency personnel.

Please ensure that the form has the most updated & accurate info.

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this card may be notified in an emergency, as needed.

Signature **Date**

Insurance Preauthorization Request

Doctor						Date	
Patient #			Computer #			Case type	
Patient Name						D O B	
Insured's name						D O B	
Relationship			Since (Date)			Injured/ill since	
Employer						Phone	
Address						Supervisor	
City		State		Zip		Note	
Insurance Company						Phone	
Address						Insured's ID#	
City		State		Zip		Group #	
Contact		Title		Phone		Claim #	
Notes							

Pre-Authorization Request			
Initial Care ☐	Update Care ☐	Primary Insurance ☐	Workers Compensation Insurance ☐
Diagnosis			
Treatment Requested			
Treatment start date		**Treatment end date**	
Treatment particulars; (Number & frequency of visits, etc.)			
Additional requirements; (Traction, Ultrasound, Physiotherapy, Exercise, Diet, etc.)			
Comments and Notes			
Doctor's Signature		**Address & Contact details**	

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Fax _____

The person named above hereby authorizes Dr. Emily Caster, PsyD **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☐ Send health information to
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name Of Person, Provider, Or Facility _____

Address _____

Phone _____

Fax _____

Scope

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

Authorization

_____

Printed name of Patient or Authorized Representative

_____ Signature of Patient or Authorized Representative

_____ Date

_____ Signature of witness

_____ Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

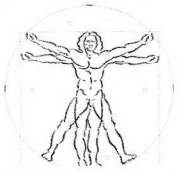
Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact a clinic office manager or site administrator for additional information about applicable copying fees.



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AUTHORIZATION FOR CREDIT CARD USE

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
ALL INFORMATION WILL REMAIN CONFIDENTIAL

NAME ON CARD: _____

BILLING ADDRESS: _____

_____

CREDIT CARD TYPE: _____ VISA _____ MASTERCARD ____ DISCOVER _____ AMEX

CREDIT CARD NUMBER: __ __ __ __-__ __ __ __-__ __ __ __-__ __ __ __

EXPIRATION DATE: _____/_____

CARD IDENTIFICATION NUMBER: __ __ __ (LAST 3 DIGITS LOCATED ON THE BACK OF THE CREDIT CARD)

AMOUNT TO CHARGE: $ _____ (USD)

I AUTHORIZE _NUANCE NEUROPSYCHOLOGY LLC_ TO CHARGE THE AMOUNT LISTED ABOVE PER SESSION TO THE CREDIT CARD PROVIDED HEREIN. I AGREE TO PAY FOR THIS PURCHASE IN ACCORDANCE WITH THE ISSUING BANK CARDHOLDER AGREEMENT.

CARDHOLDER – PLEASE SIGN AND DATE

SIGNATURE: _____

DATE: _____

PRINT NAME: _____

Nuance Neuropsychology LLC
www.nuanceneuropsych.com

PSYCHOLOGIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. To be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect the amount of your co-payment [unless we both agree that you were unable to attend due to circumstances

beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for the initial intake is $200.00 and each subsequent session is $175.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash; I am not able to process credit card charges as payment. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

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 will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-5. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. 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 report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact Community Mental Health Services of Arlington County or the mental health hotline (I can provide these numbers for you and they are listed in the phone book), 2) go to your local hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Signature of Patient or Personal Representative

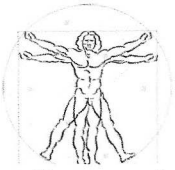
_____

Printed Name of Patient or Personal Representative

Date _____

Description of Personal Representative's Authority: _____

_____



Nuance Neuropsychology LLC
www.nuanceneuropsych.com

"Notice of Privacy Practices"

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

· Health Oversight: Virginia law requires that licensed psychologists [social workers; counselors] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health

care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

· Serious Threat to Health or Safety: Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· Records of Minors: Virginia has several laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

(For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

. · Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: May 10, 2017

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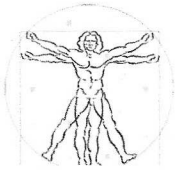

Nuance Neuropsychology LLC
www.nuanceneuropsych.com

Patient's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Nuance Neuropsychology LLC "Notice of Privacy Practices." We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: _____

Printed Name: _____

Date: _____