

Child's Name: _____

Date of Birth: _____

PARENT ASSESSMENT AGREEMENT

This document contains important information about my professional services and business policies. Please read this information carefully and make note of any questions you have so we can discuss them.

BENEFITS, RISKS, AND ALTERNATIVES TO TREATMENT

You have been given this document because you are requesting an assessment (also known as evaluation or testing) for your child. Testing can help us to understand cognitive, academic, attentional, behavioral, and/or emotional strengths and needs and can facilitate recommendations to help the child meet his or her full potential.

I will select which tests to administer based on the reasons your child was referred for testing. Examples of tests that MAY be administered include (but are not limited to): cognitive/intelligence tests; achievement tests (to measure mastery of academic skills); neuropsychological tests (e.g., memory, abstract reasoning, etc.); behavioral inventories (e.g., to assess ability to focus and concentrate, impulsivity, etc.); and tests that measure personality and emotional functioning. Additional information may be obtained from you, your child's teachers, and/or your child via interviews, observations, and/or questionnaires.

There are several potential benefits of completing a thorough assessment, including (but not limited to): understanding the probable causes of difficulties your child may be experiencing; determining what (if any) additional interventions are needed (e.g., tutoring, developing an Individualized Educational Plan (IEP), behavioral/psychological support, medication, etc.); assisting the teacher and other school staff in working with your child; and assisting you in making informed educational decisions for your child.

Some risks do exist, however. For example, in rare cases, the test results may not accurately reflect your child's abilities (e.g., due to motivation, fatigue, or illness during testing), or the diagnostic impressions may not be complete or entirely accurate. If this is the case, cautionary statements will be included whenever possible in the written report. Also, your child may experience minor discomfort during the actual testing (e.g., fatigue, frustration, anxiety, etc.). You and/or your child may be unhappy with the test results (e.g., if they indicate deficiencies in certain abilities). It is conceivable (although unlikely) that the test results and/or diagnostic impressions will produce unfair bias among professionals who receive the written report.

It is important for the school to be aware of your child's strengths and areas of development to best meet your child's individual needs. Even so, **I will not release a copy of your child's report to anyone other than you without signed permission of BOTH parents on a separate Release of Information Consent Form.**

If you have questions about the services being provided at any time, please feel free to ask for clarification. If for any reason you wish to seek services elsewhere, I will help you locate another mental health professional upon your request.

HOURS/AVAILABILITY/CONTACT INFORMATION

I am available to conduct assessments during normal business hours Mondays through Fridays, although mornings are preferred. Exceptions to typical testing times can be arranged with advanced notice. Assessments will be conducted at my office:

**31371 Rancho Viejo Road, Suite 203
San Juan Capistrano, CA 92675
(949) 858-MOTT (6688)**

Test sessions will typically last approximately 2 to 2 ½ hours (including breaks as needed/requested), and multiple sessions are usually needed to complete the assessment. Should you need to change your scheduled appointment time, please call me AT LEAST 24 HOURS IN ADVANCE. *I reserve the right to charge you for one hour of my time (\$150) for appointments that are cancelled with less than 24-hour notice.* I can be reached through my office cell phone at (949) 858-MOTT (6688). I can also be reached via email at drmott@drmott.com, although the confidentiality of email communications cannot be 100% guaranteed (see below).

The frequency with which I check messages and emails varies depending on my schedule, so *please do NOT use email, voice mail, or text messages for emergencies.* In the event of a mental health emergency, if you are unable to reach me and feel like you can't wait for a return call, contact your family doctor or the nearest emergency room and ask for the psychologist/psychiatrist on call.

CONFIDENTIALITY, PRIVACY, AND RECORD KEEPING

You will receive a copy of your child's report, which will summarize his/her performance on the tests, provide clinical impressions (aka diagnoses), and include recommendations. I am required by law and by the standards of my profession to keep testing records. As a parent, you are entitled to review your child's complete record if you wish. However, test protocols and observation notes can be misinterpreted and/or upsetting, so it is recommended that if you wish to see your child's complete record, you review it with me so you can discuss any questions you may have. In rare cases, I may determine that reviewing your child's entire record would have negative consequences for you and/or your child. In that case, I will provide the record to an appropriate mental health professional of your choice.

The confidentiality of communications between you, your child, and myself is important and is generally legally protected. Normally, information can be released only with your written permission. If you grant signed permission for the school to receive a copy of the report, it is likely that the contents will be discussed with educators and other professionals who work with your child on a "need to know" basis. Although there is every expectation that your school will protect the confidentiality of the report, I cannot be held responsible for a breach of confidentiality by school personnel.

Please note that there are some important exceptions to the overall legal and ethical requirement of confidentiality. For example, reports are required in suspected cases of abuse of a child, elderly or disabled person, as well as in situations where a person may be a danger to him/herself or another. Also (upon parental request), I may furnish the information necessary to obtain reimbursement when a third party is expected to pay for some part of the costs of services.

In most legal proceedings, the therapist-client privilege protects information about your child's assessment. Please note, however, that certain Court proceedings, actions before the Board of Psychology, or other illegal activity may limit the ability to maintain confidentiality.

Please be aware that **I do not conduct assessments or provide recommendations for Court-related proceedings.** By signing this form, you agree that:

- ✓ You will not attempt to gain advantage in any legal proceedings from my involvement with your child, and you will instruct your attorney not to subpoena me or to refer in any Court filing to anything I have said or done.
- ✓ Neither parent will ask me to testify in Court, either in person or by affidavit. You understand that I am ethically bound NOT to give my opinion about either parent’s custody or visitation suitability.
- ✓ In the case of custody disputes, if there is a Court appointed Evaluator, Guardian Ad Litem, or Parenting Coordinator, I will provide information as necessary (if appropriate Releases are signed and a Court Order is provided), but I will NOT make any recommendation about the final decision.

Occasionally, I may find it helpful to seek consultation with other professionals regarding your child. Such consultations are also legally bound by laws of confidentiality, and I will make every effort to protect confidentiality when discussing your child’s case.

Regarding Social Media, my general policy is NOT to accept “friend” requests from current or former clients or their parents (e.g., on Facebook or LinkedIn), since doing so has the potential to compromise counseling and treatment boundaries. Likewise, my general policy is NOT to “follow” current or former clients or their parents on social media sites such as Twitter or Pinterest in order to protect client confidentiality.

SECURITY OF ELECTRONIC INFORMATION

I have taken several measures to strengthen the security of electronic confidential information, including: *maintaining a password-protected laptop with virus protection; using an internet connection with firewall protection; purchasing HIPAA-compliant email; regularly backing up client information from my laptop onto an encrypted hard-drive; maintaining fingerprint security on my cell phone (my office number is a cell phone); maintaining a security certificate on my website; and not allowing anyone besides me to retrieve my confidential voice mail.* Despite these measures, the confidentiality of email and text communications cannot be 100% guaranteed (e.g., there is a very small possibility that unencrypted messages can be accessed by unauthorized people and/or that email or text messages might be sent erroneously to the wrong person). Please know that:

- ✓ **You are expected to notify me immediately if you do NOT wish to communicate electronically** (i.e., via email, text messages, and/or cell phones calls/messages).
- ✓ If you share confidential or private information with me via unencrypted email or text message, I will assume that you have evaluated the risks and made an informed decision and I will view doing so as your agreement to take the very small risk that such communication may be intercepted.
- ✓ **Your signature at the bottom of this form constitutes your consent to communicate via email and/or text.** Please note that emails and texts will be part of the clinical records.

RELEASE OF INFORMATION

Most insurance agreements require you to authorize me to provide information, including clinical impressions and in rare cases, a copy of the report or even a copy of the entire record. Once the insurance company has this information, I will have no control over what they do with it.

In order to more completely assess your child, it may be important to obtain records from previous treating professional(s). Your agreement to the release of previous treatment records may assist in the assessment of your child. **Please provide me with information on previous services received by your child and/or your family.**

| |
|---|
| My child has been previously evaluated by a medical and/or mental health professional (check one): <input type="checkbox"/> no <input type="checkbox"/> yes (list): _____ |
|---|

Child's Name: _____ Date of Birth: _____

APPROXIMATE COSTS OF SELECTED TESTS

Listed below are **FLAT FEE** costs for administering, scoring, and interpreting various assessment tools. Additional assessment tools will be used as agreed upon by you and Dr. Mott and will be billed at the rate of **\$150 per hour** (as stated in the Assessment Agreement). Although the rates listed below are an *estimated* "flat fee" cost of your child's assessment, your actual cost may vary.

| QUESTIONNAIRES | |
|---|--------|
| <input type="checkbox"/> Beck Youth Inventories, 2 nd Edition | \$ 75 |
| <input type="checkbox"/> Child Depression Inventory, 2 nd Edition (\$60 per parent and/or youth questionnaire) | \$___ |
| <input type="checkbox"/> Conners' Rating Scales (CRS-3): | |
| <input type="checkbox"/> Parent, Teacher, or Youth Self-Report: long version (\$115 per questionnaire) | \$___ |
| <input type="checkbox"/> Parent, Teacher, or Youth Self-Report: short version (\$60 per questionnaire) | \$___ |
| <input type="checkbox"/> Developmental History Questionnaire (<i>required for all assessments</i>) | \$125 |
| <input type="checkbox"/> Devereux SMD, Child or Adolescent (\$75 per parent and/or teacher questionnaire) | \$___ |
| <input type="checkbox"/> DSM-5 Level 1 and Level 2 Questionnaires (\$25 per parent and/or youth questionnaire) | \$___ |
| <input type="checkbox"/> Functional Academic Skills Checklist (\$50 per teacher questionnaire) | \$___ |
| <input type="checkbox"/> Multidimensional Anxiety Scale for Children, 2 nd Edition (\$75 per parent and/or youth questionnaire) | \$___ |
| <input type="checkbox"/> Screen for Child Anxiety Related Disorders (\$50 per parent and/or youth questionnaire) | \$___ |
| <input type="checkbox"/> Social Responsiveness Scale, 2 nd Edition (\$75 per parent and/or teacher questionnaire) | \$___ |
| ABILITY ASSESSMENTS | |
| <input type="checkbox"/> Comprehensive Tests of Phonological Processing, 2nd Edition (CTOPP-2) (<i>includes write-up</i>) | \$450 |
| <input type="checkbox"/> NEPSY-II (Neuropsychological Assessment) (<i>includes write-up</i>) | |
| <input type="checkbox"/> Attention and Executive Functioning Domain | \$425 |
| <input type="checkbox"/> Language Domain | \$275 |
| <input type="checkbox"/> Memory and Learning Domain | \$525 |
| <input type="checkbox"/> Sensorimotor Domain | \$175 |
| <input type="checkbox"/> Social Perception Domain | \$175 |
| <input type="checkbox"/> Visuospatial Processing | \$525 |
| <input type="checkbox"/> Test of Auditory Comprehension of Language, 4th Edition (TACL-4) (<i>includes write-up</i>) | \$300 |
| <input type="checkbox"/> Test of Expressive Language (TEXL) (<i>includes write-up</i>) | \$300 |
| <input type="checkbox"/> Test of Word Reading Efficiency, 2nd Edition (TOWRE-2) (<i>includes write-up</i>) | \$100 |
| <input type="checkbox"/> Wechsler Intelligence Scale for Children, 5th Edition (WISC-V) (<i>includes write-up</i>) | \$800 |
| <input type="checkbox"/> Wechsler Individual Achievement Test, 3rd Edition (WIAT-III) (<i>includes write-up</i>) | \$1150 |
| OVER→ OVER→ OVER→ OVER→ OVER→ | |

| ASSESSMENT PACKAGES | |
|---|--------|
| <input type="checkbox"/> ADHD Assessment: <i>Includes Developmental History Questionnaire, Conners' Parent, Teacher and Youth Rating Scales (long versions), Devereux SMD, Functional Academic Skills Checklist(s), observations from teacher(s), WISC-V, NEPSY-II Attention and Executive Functioning Domain subtests, records review, report with recommendations, and debriefing meeting with parents/guardians</i> | \$1800 |
| <input type="checkbox"/> Psychoeducational Assessment: <i>Includes Developmental History Questionnaire, Devereux SMD, Functional Academic Skills Checklist(s), observations from teacher(s), WISC-V, WIAT-III, records review, report with recommendations, and debriefing meeting with parents/guardians</i> | \$2150 |
| <input type="checkbox"/> Psychoeducational + ADHD Assessment: <i>Includes Developmental History Questionnaire, Conners' Parent, Teacher (and Youth) Rating Scales (long versions), Devereux SMD, Functional Academic Skills Checklist(s), observations from teacher(s), WISC-V, WIAT-III, NEPSY-II Attention and Executive Functioning Domain subtests, records review, report with recommendations, and debriefing meeting with parents/guardians</i> | \$2850 |
| OTHER SERVICES | |
| <input type="checkbox"/> Classroom Observation and Write-Up, Flat Fee <i>(regardless of time involved; includes travel time to and from the school) OR \$150 per hour, whichever is less</i> | \$450 |
| <input type="checkbox"/> Review of Previous Test Reports and Summary Write-Up with Recommendations, Flat Fee <i>(regardless of time involved) OR \$150 per hour, whichever is less</i> | \$600 |
| <input type="checkbox"/> School Meeting, Flat Fee <i>(regardless of time involved; includes travel time to and from the school) OR \$150 per hour, whichever is less</i> | \$450 |
| <input type="checkbox"/> Structured Clinical Interview with Parent(s) and Write-Up, Flat Fee <i>(regardless of time involved) OR \$150 per hour, whichever is less</i> | \$600 |

- Additional assessments as needed: (**\$150 per hour** for testing, scoring, and interpretation time)
- _____ \$ _____
 - _____ \$ _____
 - _____ \$ _____
 - _____ \$ _____

TOTAL ESTIMATED AMOUNT: **\$**

I agree to pay for the services indicated on this assessment price list. I understand that **at least 50% of the estimated amount is due at the first appointment and the balance is due upon receipt of the completed report.** Please make checks payable to Mariam Mott, Ph.D.

Signature of Parent/Guardian (MATERNAL)

Date

Signature of Parent/Guardian (PATERNAL)

Date

Updated 6/18/20

Child's Name: _____

Date of Birth: _____

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD PROTECTED HEALTH INFORMATION (PHI).

By law I am required to ensure that PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you or your child. It contains data about past, present, or future health or condition, the provision of health care services, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it on my website (www.drmott.com.) You may also request an updated copy of this Notice from me.

III. HOW I WILL USE AND DISCLOSE PHI.

I will use and disclose PHI for many different reasons. Some of the uses or disclosures will require prior written authorization, but others will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Prior Written Consent. I may use and disclose PHI without your consent for the following reasons:

- ✓ For treatment. I can use PHI within my practice to provide mental health treatment, including discussing or sharing PHI with my trainees and interns (if applicable). I may disclose PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you or your child with health care services or are otherwise involved in your or your child's care. For example, if a psychiatrist is treating you or your child, I may disclose PHI to her/him in order to coordinate care.
- ✓ For health care operations. I may disclose PHI to facilitate the efficient and correct operation of my practice. For example, I might use PHI in the evaluation of the quality of health care services that you or your child have received or to evaluate the performance of the health care professionals who provided those services (i.e., for Quality Control). I may also provide PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

- ✓ To obtain payment for treatment. For example, I might send PHI to your insurance company or health plan in order to get payment for the health care services that I have provided. Although I do not currently use a billing service, in the future I might provide PHI to business associates such as billing companies, claims processing companies, and others who may process health care claims for my office.
- ✓ Other disclosures. Your consent is not required if you or your child needs emergency treatment, provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose PHI without your consent or authorization for the following reasons:

- ✓ When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. For example, I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- ✓ If disclosure is compelled by a party to a proceeding before a Court of an administrative agency pursuant to its lawful authority.
- ✓ If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
- ✓ If disclosure is compelled by the client or the client's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
- ✓ To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to medications).
- ✓ If disclosure is compelled or permitted by the fact that you or your child are in such mental or emotional condition as to be dangerous to self or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
- ✓ If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, I may disclose PHI if I have a reasonable suspicion of child abuse or neglect.
- ✓ If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, I may disclose PHI if I have a reasonable suspicion of elder abuse or dependent adult abuse.
- ✓ If disclosure is compelled or permitted by the fact that you or your child tell me of a serious/imminent threat of physical violence by you or your child against a reasonably identifiable victim or victims.
- ✓ For public health activities. For example, in the event of your or your child's death, if a disclosure is permitted or compelled, I may need to give the County Coroner PHI information.
- ✓ For health oversight activities. For example, I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
- ✓ For specific government functions. For example, I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national secu-

riety, such as protecting the President of the United States or assisting with intelligence operations.

- ✓ For research purposes. Although I do not currently conduct research, in the future and under certain circumstances, I may provide PHI in order to conduct research.
- ✓ For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
- ✓ Appointment reminders and health related benefits or services. For example, I may use PHI to provide appointment reminders. I may use PHI to provide information about alternative treatment options, or to provide information about other health care services or benefits I offer.
- ✓ If an arbitrator or arbitration panel compels disclosure, such as when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records), or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
- ✓ If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. For example, I may release PHI when compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
- ✓ If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

- ✓ Disclosures to family, friends, or others. I may provide PHI to a family member, friend, or other individual who you indicate is involved in your care or your child's care, or who is responsible for the payment for your or your child's health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any PHI. Even if you have signed an authorization to disclose your or your child's PHI, you may later revoke that authorization in writing to stop any future uses and disclosures of PHI by me (assuming that I haven't taken any action subsequent to the original authorization).

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR OR YOUR CHILD'S PHI?

A. The Right to See and Get Copies of Your or Your Child's PHI. In general, you have the right to see your or your child's PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have the PHI but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request; if I do, I will give you the reasons for the denial in writing. I will also explain your right to have my denial reviewed.

If you ask for copies of your or your child's PHI, I will charge you not more than \$.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it and you agree to the cost in advance.

B. The Right to Request Limits on Uses and Disclosures of Your or Your Child's PHI. You have the right to ask that I limit how I use and disclose PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your or Your Child's PHI to You. It is your right to ask that PHI be sent to you at an alternate address (for example, sending information to your work address ra-

ther than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI in the format you requested without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

- D. The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your or your child's PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years, or for seven years after your child turns 18.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

- E. The Right to Amend Your or Your Child's PHI.** If you believe that there is some error in the PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to the PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to the PHI.

- F. The Right to Get This Notice by Email.** You have the right to get this notice by email. You have the right to request a paper copy of it as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES.

If in your opinion, I may have violated your or your child's privacy rights, or if you object to a decision I made about access to PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C., 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you or your child.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Mariam A. Mott, Ph.D., 28562 Oso Parkway, Suite D-437, Rancho Santa Margarita, CA, 92688. My office/cell phone is (949) 858-6688. You can also email me at drmott@drmott.com, although the contents of email communications cannot be completely assured.

VII. NOTIFICATIONS OF BREACHES.

In the case of a breach, I (Mariam A. Mott, Ph.D.) am required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, I am ultimately responsible for providing the notification directly or via the business associate. If the breach

involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. I bear the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH.

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. I (Mariam A. Mott, Ph.D.) may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. INDIVIDUALS' RIGHT TO RESTRICT DISCLOSURES; RIGHT OF ACCESS.

To implement the 2013 HITECH Act, the Privacy Rule is amended. I (Mariam A. Mott, Ph.D.) am required to restrict the disclosure of PHI about you or your child to a health plan, upon request if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring me (Mariam A. Mott, Ph.D.) to provide you a copy of your or your child's PHI if you request it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that I must provide you only with an electronic copy of your/your child's PHI, not direct access to your/your child's electronic health record systems. The 2013 Amendments also give you the right to direct me to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the Amendments restrict the fees that I may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days to 30 days with a one-time extension of 30 additional days.

X. NPP.

Most uses and disclosures of psychotherapy notes (if applicable), marketing disclosures, and sale of PHI require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE.

This version of this notice went into effect December 23, 2019.

I acknowledge receipt of this notice:

Signature of Parent/Guardian (MATERNAL)

Date

Signature of Parent/Guardian (PATERNAL)

Date *Updated 6/18/20*

Child's Name: _____

Date of Birth: _____

YOUTH ASSESSMENT AGREEMENT

I have been asked to meet with Dr. Mott so that we can understand the way I learn best. Dr. Mott and I will be completing several activities together, such as answering questions and solving problems. I know that these activities are made for children of all ages. Even though some of the questions may be easy for me, I know that some of them will be hard. I agree to do my best so that my parents, teachers, and Dr. Mott can work together to help make learning easier for me.

In general, the things I tell Dr. Mott will be private, unless she decides that she must tell someone else. I understand that Dr. Mott's first job is to make sure that everyone is safe. She is required by law and by the standards of her profession to tell others if she thinks that a child or older person is being hurt in some way, or if someone may be a danger to themselves or others. Dr. Mott may also decide to tell my parents if I am involved in dangerous activities (e.g., alcohol or drug use, suicidal thoughts, etc.). In most legal proceedings, assessment information is protected. However, information may need to be shared during certain Court proceedings.

I realize that my parents will receive a copy of Dr. Mott's report, which will help them understand the ways I learn best and will suggest some ways to help me in school. My parents may decide to give a copy of the report to my school. People who see the report (my parents, teachers, and Dr. Mott) are expected to keep the information private.

If I need to reach Dr. Mott, I can call her at **858-MOTT (6688)** or email her at drmott@drmott.com. I understand that the confidentiality of email communication cannot be 100% guaranteed.

Child's Signature

Date

Child's Name (Please Print)