Neuropsychology of Northern Virginia™
at Psychological and Life Skills Associates, P.C.
13885 Hedgewood Drive, Suite 233, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124

CHILDREN/ADOLESCENT INTAKE FORM AND DEVELOPMENTAL HISTORY QUESTIONNAIRE

(To be completed by parent(s) about child/adolescent being brought for evaluation)

Referred by:____________________Today's Date: ____________

Child's Name__________________________Age Birthdate________Home Phone________________
Home Address______________________________________City_______________Zip_____________
Mother/Guardian___________________________Employer_______________Occupation____________
Father/Guardian___________________________Employer_______________Occupation____________
Mother/Guardian Phones____________________Father/Guardian Phones_________________________
Social Security Number___________________________Email__________________________
Parent's Marital Status: Married Single Divorced Widowed
Pediatrician/Family Physician____________________________Physician's Phone___________________
Child's School_________________________________Grade Teacher___________
In case of Emergency, Please Contact______________________________Phone__________________

Has a prior psychological/neuropsychological evaluation been completed before?
If yes, name of service provider: ____
Findings of evaluation: ____

Current Family Structure: (residing in the home)

Name	Age	Relationship	Job/School	Nature of Relationship Mental Health History	Nature of Relationship with Child

Other Children: (not in home)

Name	Age	Relationship	Job/School	Mental Health History	Relationship with Child (Positive, Conflicted, etc.)

Prenatal History:

1. Prenatal care:____

2. Mother's health during pregnancy:____

3. Complications, abnormal test results or medical concerns during pregnancy: ________________________

4. Fetal exposure to alcohol, cigarettes,or drug use during pregnancy: ____________________________

5. Infant's health/weight at birth:____

6. Unusual aspects to the delivery (e.g. prematurity, lack of oxygen…)____________________________

Early Development:

7. List ages your child reached the following developmental milestones:

Sitting___ Crawling___ Walking___
Using Single Words___ Using sentences___ Toilet Trained___

8. My child's temperament as an infant and toddler were: (check as many as apply)

Easy___ Cautious___ Excitable__
Fussy___ Slow to warm up___ Colicky___
High Energy___ Shy___ Alert___

9. History of articulation problems or regression in language skills:________________________________

10. History of motor problems or regression in motor skills:______________________________________

11. History of social problems or regression in social-relatedness skills:____________________________

Family History:

12. Child's primary caretaker(s) throughout childhood:____

13. Significant family stressors or changes in your child's lifetime (e.g. death, divorce, traumatic event)____
____

Medical History:

14. Medical or mental health conditions:____

15. Previous hospitalizations and dates:____

16. Current Medications: Medication Dose Treating Physician

____
____
____
____

17. History of Psychotherapy, Occupational Therapy, Speech Therapy, Physical Therapy:

Previous Therapist Dates Issues Addressed

____
____

18. Hearing and/or vision problems: ____

School/Job:

19. Typical grades earned by your child, including any significant or recent changes in grades:____

20. History of learning disability or concerns:____

21. Repeated any grades:____

22. Child's style of interacting with teachers:____

23. Child's style of interacting with peers:____

24. Behavioral concerns at school:____

25. Extracurricular activities:____

For parents/guardians of teenagers:

26. Your goals for your teenager after graduation from high school:________________________________

27. Your teenager's job history:____

Child's Personal Characteristics:

28. Strengths:____

29. Weaknesses:____

30. Hobbies/Interests:____

31. Child's usual mood:____

32. Child's relationship with neighborhood friends:____

33. Types of discipline that are effective with your child:________________________________

Medical/ Functioning Testing and Lab Work History:

Check all medical/functioning tests that have been recently completed and report any findings:

__Blood Work	___ EEG	___Developmental
__ CT Scan	___ MRI of Brain	___Auditory Processing
__Vision	___Occupational Therapy	___Speech Therapy

History of concussion/head injury or loss of consciousness:

____

Suicide attempts/ psychiatric hospitalization history:

____

Current Symptoms: Please check all that apply and are applicable:

General:
___ Irritability
___ Aggression
___ High activity level
___ Staring spells
___ Trouble expressing him/herself
___ Frequent fatigue
___ Low energy level
___ Trouble falling asleep
___ Trouble getting up in the morning
___ Frequent awakenings during the night
___ Easily frustrated
___ Recent weight gain/loss
___ Recent changes in appetite
___ Excessive fears/worries
___ Social isolation
___ Depressed mood
___ Mood swings
___ Hopelessness
___ Anxiety
___ Anger/rage
___ Guilt
___ Grief/mourning
___ Past history of sexual abuse
___ Past history of physical abuse
___ Coping with pain
___ Aches and pains
___ Suicidal thoughts/actions
___ Desire to hurt someone
___ Drug/Alcohol use
___ Tobacco use
___ Self-Harm
___ Problems in thinking
___ Problems with memory
___ Other:________________

Physical
___ Headaches
___ Dizziness
___ Nausea
___ Vomiting
___ Urinary incontinence
___ Loss of bowl control
___ Fainting
___ Other:________________

Sensory
___ Loss of feelings/numbness
___ Tingling/strange skin sensations
___ Difficulty telling hot and cold
___ Blurred vision/blank spots
___ Brief periods of blindness
___Double vision
___Difficulty looking quickly from one object to another
___ Difficulty hearing
___Difficulty tasting foods
___Difficulty smelling/strange odors
___Other:________________

Concentration
___Distractible
___Loses train of thought
___Other:________________

Memory

Forgetting:
___Where things are left
___Names
___What you were doing
___Where you were going
___Long term events
___Needs hints and reminders
___Other:________________

Activities of Daily Living
Difficulty with:
___Dressing
___Bathing/showering
___Requires help for toileting
___Eating/feedings
___Table manners
___Meal preparation
___Making purchases (dealing with money)
___Driving
___Other:________________

Motor and Coordination
___Fine motor control difficulties
___Weakness on one side of body
___ Difficulty holding objects
___Shakiness/tics
___Changes in writing
___Balance problems
___Difficulty initiating movement
___Muscles tire quickly
___Other:________________

Nonverbal Skills
___Difficulty telling right from left
___Difficulty brushing teeth, etc.
___Getting lost in familiar places
___Difficulty recognizing objects/people
___Difficulty with puzzles, problems drawing
___Sow reaction time
___Difficulty recognizing facial expressions
___Other:________________

Speech/Language/Academic Skills
Difficulty with:
___Word finding/naming
___Staying on topic
___Understanding what others say
___Reading phonetically
___ Comprehending reading, writing, spelling, math
___Letters move on page, must use finger to track reading
___Speech behind/slurred, unusual speech sounds
___Other:________________

Problem Solving
Difficulty with:
___Figuring out how to compete new tasks
___Planning/organizing
___Quick thinking
___Sequential tasks
___Changing a plan/activity/transitioning
___Completing tasks in time
___Multitasking
___Other:________________

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NOTICE OF OUR PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD & INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of Neuropsychology of Northern Virginia™. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your mental health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your mental health record. You may obtain an accounting of disclosures of your mental health information, request communications of your mental health information by alternative means or at alternative locations, revoke your authorization to use or disclose mental health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: The Neuropsychology of Northern Virginia™ is required to maintain the privacy of your mental health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected mental health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. We will not use or disclose your mental health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

***We will use your mental health information for treatment*:** Information obtained by your therapist will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your mental health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, relevant history, and treatment given.

Law enforcement: We may disclose mental health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your mental health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. We will attempt to contact you first to see if you consent to such release.

Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services. We will discuss this with you as appropriate.

Abuse of Elderly or Incapacitated Adults: When we have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, we are required by law to make a report and provide relevant information to the Virginia Department of Social Services. You will be notified of this action unless your therapist believes that it would put you at risk of serious harm.

Health Oversight: The Virginia Board of Health Professions, including the Boards of Psychology, Social Work, and Counseling, has the power to subpoena relevant records should we be the focus of an inquiry.

Judicial or Administrative Proceedings (Court Orders): If you are involved in a court proceeding and a request is made for information about your treatment, we will not release information without your written authorization. If we receive a Subpoena for your records (of which you have been served, along with the proper notice required by state law) we are required to respond. We will attempt to contact you first to see if you consent to such release. If you object, you may file a motion, with the clerk of the court to move to quash (block) the subpoena. If you pursue this, notify your therapist as soon as possible. We are then required to place your records in a sealed envelope and provide them to the clerk of the court so that the court can determine whether the records should be released.

Serious Threat to Health or Safety of Others: If you communicate to us a specific and immediate threat to cause serious bodily injury or death to an identified or to a readily identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect the threatened person.

Danger to Self: Your therapist can break confidentiality if you (or your child) are in imminent danger of hurting yourself, in order to keep you (or your child) safe. This may include notifying emergency personnel.

Worker's Compensation: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant PHI to you, your employer, the insurer, or a certified rehabilitation provider.

Debt Collection: Your name can be reported to a collection agency and/or a credit bureau if you fail to pay your bill. You will be notified before such a report is made.

Legal Defense: Disclosure may be made if a therapist must arrange for legal consultation if a patient takes legal action against a therapist.

Effective Date: This notice will be effective on April 14, 2003

Modification & Amendment: This notice may be modified or amended by other documents, upon notification from your healthcare provider.

To obtain more information, or if you have any questions about this form, please contact our privacy officer:

Dr. Christopher T. Haley
13885 Hedgewood Drive #245
Woodbridge, VA 22193
(703)490-0336

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Evaluation Consent Form

Nature and Purpose of Assessment: The goal of neuropsychological assessment is to determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive functions. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your background and current medical symptoms we may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of
certain topics, reading, drawing figures and shapes, listening to recorded tapes, viewing printed material, and manipulating objects.
Foreseeable Risks, Discomforts, and Benefits: For some individuals assessments can cause fatigue, frustration, and anxiousness.
Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law.

What to Expect/Additional Information:
If you have been referred or believe that your child would benefit from a neuropsychological evaluation, call our front desk in order to schedule an appointment. Please complete the intake form and bring it to your first appointment. Be sure to bring with you to the first appointment any relevant medical records, school records (grades, IEP/504 plan, psychological evaluations, etc.) as well as any prior evaluations (occupational therapy, speech therapy, neuropsychological, developmental vision, etc.).

While the evaluations for children 6 and under can vary in length of time, those 6 and older can expect to obtain 8 hours of direct patient time (intake, testing, and feedback). This does not include the numerous “behind the scenes” hours which include reviewing relevant records (medical, school, etc.), developing an individualized testing battery, scoring, interpreting, and report writing. This is why a neuropsychological evaluation is an invaluable asset to your child’s care. Also, intake paperwork should be brought completed to the first appointment- if you have not completed it, please arrive 45 minutes prior to your appointment and complete in our waiting room.

Keep in mind that any relevant information that is provided during the evaluation process will be included in the written report, as deemed appropriate. Also, a diagnosis is not always warranted if the data does not support one.

Appointments:
Age group: 2 years and 6 months - 5 years and 11 months
1st appointment (Intake): Only the parents are asked to attend the clinical intake interview appointment (1h) as it tends to be difficult to discuss certain matters with younger children in the room. Upon the completion of this appointment, the testing and feedback appointments will be scheduled. Be sure to bring with you all paperwork mentioned earlier. Expect to go home with various screeners to complete and bring to the next appointment.
2nd appointment (Testing): This appointment can vary in length but will typically range from 1 to 3 hours. You may be asked to sit in with your child during some of the testing or you will be asked to remain in the waiting room. Do not leave the building while your child is testing.
3rd appointment (Feedback): Again, only the parents are asked to attend the feedback appointment (1h). This should take place approximately 3 weeks after testing is completed. At this time, the results of the evaluation will be discussed with the family.

Age group: 6 years old and up

1st appointment (Intake): The parents AND child are asked to attend the clinical intake interview appointment (1h) as the neuropsychologist will keep the child to begin testing (1h) upon the completion of the intake (2h total appointment time). Upon the completion of this appointment, the additional testing and feedback appointments will be scheduled. Be sure to bring with you all paperwork mentioned earlier. Expect to go home with various screeners to complete and bring to the next appointment.

2nd appointment (Testing): This appointment can vary in length but will typically involve 5 hours. A typical testing day includes testing 9am to 12pm, an hour lunch break where you and your child are welcome to leave the office, and testing 1pm to 3pm. You may be asked to sit in with your child during some of the testing but will likely be asked to remain in the waiting room. Do not leave the building while your child is testing unless they are of an approved age for you to do so.

3rd appointment (Feedback): Unless the child is 18 years old or of an age where they can comprehend and benefit from the discussion, only the parents are asked to attend the feedback appointment (1h). This should take place approximately 3 weeks after testing is completed. At this time, the results of the evaluation will be discussed with the family.

On rare occasions, testing may need to be split up into two testing days or additional hours of testing may be required. This will be discussed on a case by case basis as it applied to your child.

Please contact our front desk in order to discuss payment questions.

Evaluation Cost:

$2,100 for ages 6 years and older- this includes a clinical intake, up to 6 hours of testing, feedback session, review of prior records, scoring, interpreting data, and report writing

$1,575 for ages under 6 years-this includes a clinical intake, up to 3 hours of testing, feedback session, review of prior records, scoring, interpreting data, and report writing

If testing goes longer than the allotted amount of time, there will be an additional $175 fee per extra hour of testing. We are understanding of financial restrictions and will work with families on a sliding scale fee as deemed necessary and if approved in advance.

While we do not directly deal with out of network insurance, once the evaluation is completed, you will be provided with the necessary information to submit to your insurance to attempt to obtain reimbursement yourself. Reimbursement by out of network insurance is not guaranteed on our end. Payment will be collected on three separate occasions (during intake, testing, and feedback appointments) and final amount will be adjusted as needed during the last feedback appointment. Keep in mind that the private pay process will allow you to receive services faster since insurance clearance for neuropsychological services may take up to several months. Due to the limited time of the neuropsychologist, attending any school meetings in person will be unlikely. However, phone/email consultations with the school can be scheduled on a case by case basis for an additional fee.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

______________________________________ ________________________

Patient Signature Date

______________________________________ ________________________

Parent/Guardian or Authorized Surrogate (if applicable) Date

______________________________________ ________________________

Witness Signature Date

REPORT RELEASE POLICY UPDATE

04/2017

Please note that while the clinician will meet with you to verbally discuss the findings of the evaluation approximately 3 weeks upon the completion of testing, we will release the actual report and mail it to you just as soon as all payment has been collected. This includes insurance reimbursement, copays, private pay, or payment covered by the school system.

I have read and agree with the above statement. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

_________________________________ _____________________

Patient Signature Date

_________________________________ _____________________

Parent/Guardian or Authorized Surrogate Date

_________________________________ _____________________

Witness Signature Date

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CUSTODY ORDER VERIFICATION FORM

Patient Name: ____________________________

Date of Birth: ____________________________

In cases where the patient is a minor and the patient's parents are separated or divorced or legal guardianship exists, we require that you provide a photocopy of your complete Custody Order as it relates to your minor child. If you do not provide a copy of your Custody Order, we will be unable to provide services to your child.

The custody order must include the custody arrangement and healthcare responsibilities of each party. The custody order will provide your doctor with information as to the status of the legal custody of the minor, as well as any specific language that may impact a parent or guardian's right to consent to mental health treatment. Joint Legal Custody can be awarded separate from Joint Physical Custody. Joint Legal Custody means that either parent acting alone may consent to mental health treatment unless the order of Joint Legal Custody has language to the contrary. Orders specifically requiring shared medical decision making responsibilities will require the consent of both parents. If you need help determining your rights to obtain and authorize mental health treatment for your minor child, please contact your legal representative. Your signature below certifies that you have read and understand the requirements as they relate to providing our office with a copy of your custody order and authorizing mental health services for your minor child in the event of separation, divorce or legal guardianship:

Check here____if there is no record of any Custody Order for this patient and sign and date below:

____ ____________________________

Signature of Parent/Legal Guardian: Date:

Check here _ if you have provided our office with a copy of the current Custody Order and sign and date below:

____ ____________________________

Signature of Parent/Legal Guardian: Date:

____ ____________________________

Signature of other Parent/Legal Guardian (when applicable): Date:

Describe order agreement details below:

____ ____________________________

Signature of Witness (office employee): Date:

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Our Financial Policy

Welcome to the office of Neuropsychology of Northern Virginia™ at Psychological and Life Skills Associates. In order to ensure the efficiency of our practice, we wish to explain our policy with regard to financial responsibility for sessions with the psychotherapists from this office.

All payments are due prior to each session. We do participate with a limited number of insurance carriers. You are responsible for any costs that your insurance does not cover. While we do not directly deal with out of network insurance, once the evaluation is completed, you will be provided with the necessary information to submit to your insurance to attempt to obtain reimbursement yourself. Reimbursement by out of network insurance is not guaranteed on our end. Payment will be collected on three separate occasions (during intake, testing, and feedback appointments) and final amount will be adjusted as needed during the last feedback appointment. Keep in mind that the private pay process will allow you to receive services faster since insurance clearance for neuropsychological services may take up to several months. Due to the limited time of the neuropsychologist, attending any school meetings in person will be unlikely. However, phone/ email consultations with the school can be scheduled on a case by case basis for an additional fee.

Our Late Cancellation/No-Show Policy

If you are unable to keep a scheduled appointment, you are required to give us at least a 24- hour notice. Late cancellations (with less than 24 hours' notice) and No Shows (missing a scheduled appointment) are charged $75 per hour of appointment, regardless of the reason. This fee cannot be billed to insurance.

Statement Fee

All payments are due at the time of service. If a balance is owed and a statement is mailed to you, you will be charged a $5.00 statement fee for each statement sent to you.

Collections Services

We are contracted with collection services to recover any money owed to Neuropsychology of Northern Virginia™.

Returned Checks

The return of a check (electronic or paper) issued to Neuropsychology of Northern Virginia™ will result in a $25.00 returned check fee being placed on the account of the patient, or individual, on whose behalf the check was presented for each returned check, no matter the reason.

The undersigned has read, understands, and agrees to the above terms and conditions.

____________________________________ ____________________
Signature of Person Financially Responsible Date

________________________________ ____________________________
Address (if other than patient's) Signature of Therapist/Witness

____
Date of birth of financially responsible party

All Payments are Due at the Time of Your Appointment
And You Must Agree to One of the Following (please initial one):

_________ *Initial here*

I agree to pay my session fee/co-pay in full at the time of service using one of the methods below.

1. BY CASH: We will gladly accept cash payments and will provide you with a receipt of payment.

2. BY CREDIT: We accept all major carriers.

3. BY CHECK: Please make checks payable to ***Neuropsychology of Northern Virginia™***. You may give the check to your therapist or the office staff.

_________ *Initial here*

I request that my credit or debit card be charged for each session at the time of service. (Please complete below)

NAME OF CLIENT ______________________________
Card # ______________________________
Exp date ______________________________
Sec code ______________________________
Billing zip ______________________________
Name of Cardholder ______________________________
Signature ______________________________
Address (if different than above)
____
____

Insurance Information

Ins. Co. (Name/Addr):______________________________

Policy Holders Name:____________________DOB:__________ SSN and Insurance ID:__________

If Military (Active/Retired):______________________________

Any secondary insurance?(if so, name of company)____________________

Policy Holders Name (if different from above):______________DOB:________

SSN and Insurance ID:______________________________

NOTE: Tricare Options Standard please alert your therapist if you have used any of your mental health benefits since October 1.

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Consent for Nonsecure Communications

We will use reasonable means to protect the security and confidentiality of email information sent and received. However, because the nonsecure nature of these communications, we cannot guarantee the security or privacy and are not liable for improper disclosure of confidential information that is not caused by our intentional misuse.

The use of unencrypted email can be a convenient and fast way to communicate between a client and provider. As a client, you have the right to use this form of communication.

The types of information that are most often communicated via e-mail include: appointment scheduling, transmission of blank office forms or paperwork, referral information and answering basic questions. It is preferred to discuss private matters in session and not through electronic communication.

Transmitting client information by e-mail has a number of risks that clients should consider before using e-mail to communicate with your provider. These include, but are not limited to, the following risks:

RISKS OF USING EMAIL COMMUNICATION

- Can be circulated, forwarded and stored in numerous paper and electronic files.
- Can be immediately broadcast worldwide and be received by unintended recipients.
- Senders can easily type in the wrong email address.
- Is easier to falsify than handwritten or signed documents.
- Backup copies may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect e-mails transmitted through their systems.
- Can be intercepted, altered, forwarded, or used without authorization or detection.
- Can be used to introduce viruses into computer systems.
- Can be used as evidence in court.

CLIENT OBLIGATIONS WHEN CONSENTING TO E-MAIL COMMUNICATION

- Use e-mail for general client information only. Do not use for medical emergencies, other time sensitive matters, or for non-general medical information.
- Follow-up with provider if you have not received a response within 5 business days.
- Take precautions to preserve confidentiality. Use screen savers and safeguard your computer password.
- Inform your provider of any changes to your e-mail address.
- Withdraw consent to email client information through hardcopy written communication to your provider.
- I understand that I may also communicate with my provider via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

☐ I **do not** grant permission to be contact by email even when initiated by me.

OR

I agree to the following non-secure communication with my provider:

☐ Email

____

Client Signature Printed Name Date

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Consent for Release and Use of Confidential Information

And

Acknowledgement of Notice of Privacy Practices

I,____hereby
(Name of Patient or Authorized Agent)
give my consent to Neuropsychology of Northern Virginia™ to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ______________________________.

I acknowledge the review and/or receipt of the Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to my therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my mental health information. Written revocation of consent must be sent to our office.

I understand that I have the right to request that the practice restricts how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed:____Date:_______________

If you are not the patient, please specify your relationship to the patient_________

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Charges for Ancillary Services

Please be aware that it is our policy to charge for non-clinical services. Such services include, but are not limited to, telephone consultations with other providers or schools, writing letter on behalf of clients, completing paperwork at the request of clients (eg. filling out disability paperwork), and fielding emergency calls. Charges will reflect the time needed to complete the service and is billed in 15 minute increments at a rate of $250/hour.
***Please note that advance notification will be sent before additional charges are applied.**

For example:

15 minutes = $62.50

30 minutes = $125.00

45 minutes = $187.50

60 minutes = $250.00

Charges for Medical Records

Searching and Handling Fee - $10
Pages 1 - 50: $0.50 per page
Pages 51+: $0.25 per page

I have read, understand, and agree to the above office policy.

______________________________ ________________
Signature of Patient, Parent, or Guardian Date