Gricelda Fragoso, PsyD.

INFORMED CONSENT

This Agreement contains important information about my professional services and business policies. When you sign this document, it will also represent an agreement between you as the client and me as your service provider.

PSYCHOLOGICAL SERVICE – Neurocognitive or Psychological Evaluation

The mental health service you elected me for is psychological, developmental, or neuropsychological testing or evaluation. Testing usually includes some combination of interview with the client and third parties in which relevant history is gathered, a records review, subjective rating forms completed by the client/parent/relevant third party, objective testing, test scoring, test data interpretation, report writing, and feedback.

The length of time that this process takes depends on the history and complexity of the problem, length of records, and the referral question itself.

The goal of testing is usually to answer a question about diagnosis, level of functioning, suitability for a specific capacity, and provide guidance for treatment.

I have read and understand the above Psychological Testing Services ______
initials

APPOINTMENTS

Testing or evaluations usually take several hours, involving an initial interview followed by testing. Brief testing can be accomplished in a single day and extensive testing may require two days. When indicated, a final feedback session is scheduled to verbally discuss the findings and recommendations in the report. A final report is provided at this session.

Because of the length of time reserved, a deposit of 25% of the cost is obtained at the time of the reservation. If you cannot make your scheduled appointment it is important that you cancel as soon as possible and no later than 3 business days in advance. The deposit is returnable and transferable up to this point**.** This deposit is **nonrefundable** and **nontransferable** if the cancellation occurs within 48 hours of the appointment.

I have read and understand the above section on Appointments/Sessions ______
initials

PROFESSIONAL FEES

The typical fee for a comprehensive psychological or neuropsychological evaluation ranges from $750 to $2000 and depends and the extent of the investigative work required for a competent evaluation. This fee applies to the initial interview, records review, testing,

scoring, interpreting and report writing, collateral interviews with third parties. Fees do not include consulting with professionals, preparation of records other than your report, and performing additional services at your request. The agreed upon fee for your service is $2000 and includes both neuropsych and psychological testing. A report will be provided to the client and the referring clinician.

I have read and understand the above section on Professional Fees

______ **initials**

BILLING & PAYMENTS

50% of the testing fee will be collected at the time of the initial interview. The remainder can will be due on the day of testing. Testing services must be paid in full prior to the release of the final report.

By signing this document, you are stating that you understand that you are responsible for any and all fees for services provided by me to which you have consented and/or requested, and that you are financially responsible for services consumed.

I have read and understand the above subsection on Billing & Payments.

______ **initials**

LEGAL PROCEEDINGS

If you become involved in legal proceedings that require my participation, you will be billed for all of my professional time, including preparation and transportation costs, even when called to testify by another party. I will charge a fee per hour for preparation and for attendance at any legal proceeding; the latter is charged from the time of leaving the office until return. These fees will be discussed with you prior to rendering any services. Such fees are considerably higher than testing fees and must be paid prior to legal proceedings.

I have read and understand the above subsection on Legal Proceedings.

______ **initials**

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between clients and psychotherapists. In most situations, I can only release information about your treatment if you sign a written authorization form that meets certain legal requirements. Situations that do not require your authorization include:

- Consultation with other health professionals about your case. No identifying information is provided and other mental health professionals are also legally bound to keep the information confidential.
- Handling of your record by administrative staff for office-related activities. All staff members have been given training about protecting your privacy and have signed nondisclosure agreements agreeing to protect your confidentiality.

- Disclosures required by health insurers
- Collection of overdue fees by a collection agency.

There are some other situations where I am ***permitted or required*** to disclose information without your consent or authorization:

- A court proceeding in which a court-order is presented for information concerning your diagnosis and treatment.
- A government agency requesting information for health oversight activities.
- To defend against a complaint or lawsuit filed by a client.
- A client-filed worker's compensation claim.

These are some situations in which I am ***legally obligated*** to take actions:

- Suspicion of child abuse or neglect.
- Suspicion of depend adult abuse, neglect, or exploitation.
- When a client communicates an explicit threat to kill or inflict bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat or a history of violence.
- If the client threatens to harm herself/himself.

I have read and understand the above section on Limits on Confidentiality.

______ **initials**

PROFESSIONAL RECORDS

The laws and standards of the mental health profession require that I keep Protected Health Information about you in your Clinical Record. My Clinical Records are maintained electronically. You may request a copy of your Clinical Record in writing. The request may be accommodated EXCEPT in circumstances that involve danger to yourself and/or others, where information has been supplied to us confidentially by others, or *if the information has been gathered in reasonable anticipation of or specifically for use in litigation*.

I have read and understand the above section on Professional Records

______ **initials**

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement and/or the Notice of Policies and Practices to Protect the Privacy of Your Health Information.

I have read and understand the above section on Client Rights

______ **initials**

Minors & Parents/Guardians (skip if does not apply)

Guardians are required to supply identification and court documents that designate them as legal guardians. Clients under 18 years of age who are not emancipated should be aware that the law may allow parents to examine their child's record.

I have read and understand the above section on Minors & Parents ______
initials

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT IN ITS ENTIRETY AND AGREE TO ITS TERMS AS IT RELATES TO YOU AND/OR YOUR CHILD. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA REQUIRED *Notice of Policies and Practices to Protect the Privacy of Your Health Information* AS DESCRIBED ABOVE.

______________________________________ __________________
Client Signature Date

______________________________________ __________________
Parent Signature (if applies) Date

CREDIT CARD AUTHORIZATION

Required

I understand that Dr.G's policy is to hold a credit card on file from which she can charge late cancellations that I consented to above and unpaid fees after consumption of services. I understand that a testing report will not be provided until my account is settled.

The person financially responsible for the cost of this service is_________________________________.

VISA / MasterCard / Discover / American Express

____
Card Owner Signature Date