The NeuroDevelopment Center
245 Waterman Street, Suite 200 Providence, RI 02906
575 Mount Auburn Street, Suite B-102 Cambridge MA 02138
(401) 351-7779

Date: ______________________

Patient name: ____

Sex: ____

Date Of Birth: ____

Address: ____

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Email: ____

Home phone: ____

Cell phone: ____

Work phone: ____

Occupation: ____

Employer/School: ____

Marital status: ____

Emergency contact: ____

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Neurologist/Mental Health Providers (i.e. counselors, psychologists, etc.)

1) Name: ____

Address: ____

____

Phone: ____

2) Name: ____

Address: ____

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Phone: ____

Patient's Primary Care Physician:

Name: ____

Address: ____

Phone: ____

Please complete if patient is a child:

Parent 1: ____

Address: ____

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Home phone: ____

Cell phone: ____

Work phone: ____

Parent 2: ____

Address: ____

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Home phone: ____

Cell phone: ____

Work phone: ____

Parents' marital status:
___ Married ___ Divorced ___ Never married

If parents not married, please answer below:

Who has legal custody:

___ Mother sole ___ Father sole ___ Joint custody

Who is seeking services:

___ Mother ___ Father ___Jointly agreed

Who is legally responsible for all costs:

___ Mother ___Father

Last 4 digits of SS# of responsible party:

Please note: Before any services are provided, the parent who is legally responsible for fees MUST sign the attached financial agreement.

How did you hear about the NeuroDevelopment Center?

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Reason for Referral:

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NeuroDevelopment Center Social Media Informed Consent

This document outlines our office policies related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, we encourage you to bring them up when you meet with your psychologist. As new technology develops and the Internet changes, there may be times when we need to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions about this, please bring them up when you meet with your psychologist so you can talk more about it.

FANNING or LIKING

We keep a Facebook page for The NeuroDevelopment Center to allow people to share our blog posts and practice updates with other Facebook users. All of the information shared on this page is also available on our website. You are welcome to view our Facebook Page and read or share articles posted there, but we do not accept clients as Fans of this Page. We believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list. The American Psychological Association's Ethics Code prohibits soliciting testimonials from clients. We feel that the term "Fan" comes too close to an implied request for a public endorsement of my practice. You are of course free to "Like" us on Facebook, but we want to make sure you are aware that doing so may suggest to others that you are a client. Note that you should be able to subscribe to the Facebook page via RSS without becoming a Fan and without creating a visible, public link to our Page. You are more than welcome to do this.

FOLLOWING

We publish a blog on our website and post psychology news on Twitter. We have no expectation that you as a client will want to follow our blog or Twitter stream. However, if you use an easily recognizable name on Twitter and your psychologist happens to notice that you've followed us there, you may briefly discuss it and its potential impact on the therapy working relationship. Our primary concern is your privacy. If you share this concern, there are more private ways to follow us on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to our content. You are welcome to use your own discretion in choosing whether to follow us. Note that we will not follow you back. We only follow other health professionals on Twitter and do not follow current or former clients on blogs or Twitter. We believe that casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on the therapy working relationship. If there are things from your online life that you wish to share with your psychologist, please bring them into your sessions where you can view and explore them during the therapy hour.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and we do not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with us in public online if you have an already established client/therapist relationship. Engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact us between sessions, the best way to do so is by phone.

USE OF SEARCH ENGINES

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.

GOOGLE READER

We do not follow current or former clients on Google Reader and do not use Google Reader to share articles. If there are things you want to share with us that you feel are relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into our sessions

BUSINESS REVIEW SITES

You may find The NeuroDevelopment Center on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that our listing is NOT a request for a testimonial, rating, or endorsement from you as our client. The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with us about your feelings about your experiences at our center, there is a good possibility that we may never see it. We hope that you will bring your feelings and reactions directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit.

None of this is meant to keep you from sharing that you are in therapy wherever and with whomever you like. Confidentiality means that WE cannot tell people that you
are our client and Psychologists' Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that you receive psychological services at the NeuroDevelopment Center or how you feel about the services you receive in any forum of your choosing. If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

LOCATION-BASED SERVICES

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from our office or if you have a passive LBS app enabled on your phone.

EMAIL

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. If you choose to communicate with us by email, be aware that all

emails are retained by your Internet service provider and by ours. While it is unlikely that someone will be looking at these messages, they are, in theory, available to be read by the system administrator(s) of your Internet service provider.

We prefer using email only to arrange or modify appointments. Please indicate your consent to receive email for this purpose by signing below.

Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us.

You should also know that any email we receive from you that contains material related to the therapy as well as any responses that we send to you become a part of your legal medical record.

CONCLUSION

Thank you for taking the time to review our Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, please bring them to the attention of the psychologist you are seeing so that you can discuss them.

Please indicate by signing below that you have read and understand and consent to these conditions.

____
Client name

____
Signature of client or responsible party

____
Date

PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to the NeuroDevelopment Center. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that you can discuss them with your psychologist. When you sign this document, it will represent an agreement between you and the NeuroDevelopment Center and your psychologist .

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you bring forward. There are many different methods your psychologist may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you talk about both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Your first session or several sessions will involve an evaluation of your needs. By the end of the evaluation, your psychologist will be able to offer you some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the psychologist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, please discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

Your psychologist will usually schedule one 45-50-minute session per week at an agreed upon time, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to make the scheduled visit. You will be charged an administrative fee of $50 unless you provide 48 hours advance notice of cancellation. This fee can be waived if you and your psychologist both agree that you were unable to attend due to circumstances beyond your control. If it is possible, we will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

Our fees vary by type of service. You may ask the receptionist for a list of charges by type of service. Please note however that the amounts that insurance companies pay are based on their allowable rates and differ from our rates. The fee that you are required to pay for a visit is determined by your insurer's allowable rate and the specifics of your policy regarding co-pays, co-insurance, deductibles, and so on. Our receptionist can explain the details to you if you have any questions.

In addition to face to face appointments, we charge for other professional services you may need and agree to such as telephone conversations lasting longer than 15 minutes, attendance at meetings at school or with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of your psychologist. These services are not covered by your insurer so the fees will be your responsibility entirely. If you become involved in legal proceedings that require participation from your psychologist, you will be expected to pay for the time taken by your psychologist even if he or she is called to testify by another party. Because of the difficulty of legal involvement, we charge $200 per hour for preparation and attendance at any legal proceeding.

INSURANCE REIMBURSEMENT

In order 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. Your psychologist will fill out forms and provide you with assistance so that you receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of all fees. Although we do our best to verify your coverage with your insurer, we cannot guarantee that your services here will be covered in part or whole. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course we will provide you with whatever information we can based on our experience and will try to help you understand the information you receive from your insurance company.

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 authorization before they 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 clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow your psychologist to provide services to you once your benefits end. If this is the case, your psychologist will refer you to another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to 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, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

Once you have all of the information about your insurance coverage, you may want to discuss with your psychologist what you can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract.

CONTACTING US

Our receptionist is available for phone calls between 9am and 6pm Monday through Friday. Your psychologist is usually not immediately available by telephone, but you may leave a message on his or her confidential voicemail during office hours. Your psychologist will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform your psychologist of some times when you will be available.

After office hours, your call will be directed to an answering service. For emergencies, there is a psychologist on call after office hours. If for any reason, our psychologist on-call is unable to reach you after hours, please contact your nearest emergency room. If your psychologist will be unavailable for an extended time, you may contact the psychologist who is covering through our main number during office hours or through the answering service after hours.

PROFESSIONAL RECORDS

The laws and standards of professional practice require that we keep treatment records. You are entitled to receive a copy of your records, or your psychologist can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in the presence of your psychologist so that you can discuss the contents with him or her. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. [At the end of your treatment, I will prepare a summary of our work together for your parents, and we will discuss it before I send it to them.]

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent your psychologist from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order testimony from your psychologist if he/she determines that the issues demand it.

There are some situations in which your psychologist is legally obligated to take action to protect others from harm, even if he or she has to reveal some information about a client's treatment. For example, if your psychologist believes that a child, elderly person, or disabled person is being abused, he or she must file a report with the appropriate state agency.

If your psychologist believes that a client is threatening serious bodily harm to himself or to another, he or she is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, your psychologist may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations rarely occur. If a similar situation does occur, your psychologist will make every effort to fully discuss it with you before taking any action.

Your psychologist may occasionally find it helpful to consult other professionals about a case. During a consultation, your psychologist will make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. If you don't object, your psychologist will not tell you about these consultations unless I feel that it is important to the work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss with your psychologist any questions or concerns that you may have at your next meeting. Your psychologist will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex.

Your signature below indicates that you have read the information in this document and agree to abide by its terms.

________________________________ ______________________________ ____________

Client's name Client or parent/guardian signature Date

Client Financial Agreement

Our primary goal is to provide you with quality mental health services. In order to allow our staff to focus on this care, we have developed the following policies regarding payment for services.

Responsibility for fees

- The NeuroDevelopment Center does not accept assignment from all insurance companies. If we do not accept your insurance, you are responsible for payment of all fees at the time that the service is delivered. We will provide you with a statement after each session that contains the information for reimbursement.
- For subscribers to insurance plans we do accept, **you are responsible to pay any claims denied by your insurer** within 15 days of receiving notice of denial. This is true even if you appeal the denial.
- We cannot and do not guarantee that an insurance company will reimburse you for any of our services. Although we have done our best to verify your coverage, due to the complexities of the insurance system, **we cannot guarantee that you will in fact be so covered.**
- Do not assume that any insurance reimbursement made to you by your insurer for one of our services will be made for a different type of service. **Be sure to check with your insurer regarding coverage for each type of service you obtain from our Center.**
- If a service is to be paid by a school system, we will need to have written acceptance of responsibility to pay for the service by a school official prior to service.
- If your check is returned, a $35 returned check fee will be assessed.
- The NeuroDevelopment Center utilizes a collections agency. If your account is still unpaid after four statements, your account will automatically be sent to collections. Ongoing services will be terminated. We will provide you with a referral for treatment in another center. It is the policy of our collections agency to report delinquent accounts to credit bureaus. If your account is sent to collections, you will be responsible for the collections fees and attorney fees, in addition to the original charges.
- Should there be any change in your financial circumstances, making for financial hardship, please discuss this with our office manger as soon as possible so that we may make arrangements for payment.

Time of Payment

- Payment is due at the time of your visit. You may pay with cash, check, credit card, or money order. If you plan to pay by check, please have a check ready to give to the receptionist when you check in.
- We will keep a signature and credit card information on file for every client. In the event that you cannot or do not pay the fee for your visit, we will submit a charge to your credit card. We ask you to sign below indicating your agreement and consent to this procedure. Your card will be charged only if you do not pay at the time of your visit, or if you prefer that means of payment. **No services can be provided without this agreement.**

Billing information

- Please notify us immediately if there is any change in your billing information.
- Please address questions about billing to our office manager, 401 351-7779, extension 100.

Cancellations/missed visits

- **Should it be necessary to cancel an appointment, please contact The NeuroDevelopment Center at least 48 hours in advance.** Without this notice, a no show fee of $50 will be charged to your account. This fee will not be paid by insurance. It will be billed as an administrative charge.

I have read and understand the policies described above and agree to these terms regarding fees and payment.
Credit card information optional/Signature required

__________ ____________________________________ _________________________________ ____________
Card type Name on card Card number Exp date

_________________________________ ____ ___________
Print name Signature Date

qEEG and Neurofeedback Services for BCBSRI Subscribers

Blue Cross Blue Shield of RI has informed us that neither our neurofeedback services nor our quantitative EEG services are covered services under their policies.

Neurofeedback is excluded under the terms of the contract for most policies. Other forms of biofeedback are covered under Rite Care and Medicare, but only for a limited number of specific conditions, most of which cannot be addressed with neurofeedback.

EEG services are covered when provided by a physician in order to diagnose a neurological medial condition. Because we use quantitative EEG for the purpose of guiding neurofeedback, it is considered incidental to a non-covered service and therefore is not covered.

If you choose to appeal BCBSRI's determination, please contact BCBSRI customer service department.

Because these services are not covered, you are personally responsible. We therefore request that you pay for each service at the time it is delivered.

I have read and understand these policies and agree to accept financial responsibility for these services. I will pay at the time of each visit.

Print name: ____

Signature: ____

Date: ____

RESEARCH

We frequently utilize our data related to diagnosis and treatment for research purposes, allowing us to learn more about the best ways to help patients. Often, the studies we conduct require informed consent to use this information for research and publication. **We never divulge personal identifying information, thus your identity would never be revealed.**

Further, no experimental methods are used in these studies, only data on the outcome of the usual diagnostic and treatment procedures that you would normally receive at our office. If any experimental research were to be done here, you would be informed well ahead of time and separate consent for this would be sought.

I consent to have personal health information used for the purpose of research, **provided no personal identifying information about me is published.**

____ ______________

Patient's Signature (parent/guardian if patient is a minor) Date

____ ______________

Witness (staff member) Date

NeuroDevelopment Center
245 Waterman Street, Suite 200, Providence RI 02906
575 Mount Auburn Street, Suite B-102, Cambridge MA 02138

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL HEALTHCARE INFORMATION

Patient:____ Date of Birth:_____________

Street:____ City:_____________________________

State:_______________________________________ Zip Code:____________ Phone number:_________________________

This Authorization permits the NeuroDevelopment Center, Inc staff to discuss and/or disclose protected health information concerning the patient named above to the Designated Party named below. This Authorization also permits the Designated Party named below to discuss and/or disclose protected health information concerning the patient named above to the NeuroDevelopment Center, Inc.

Designated Party:____

Street:____City:____

State:____ Zip Code:__________ Phone number:_______________________

This information will be used or disclosed for the following purposes:____

____

Please read below carefully before signing this document:

1. Please note all Clinicians at the NeuroDevelopment Center reserve the right to omit raw testing materials and observation notes from medical records.
2. I understand I will be charged for medical record requests: $15.00 plus .25 cents per page for the first 100 pages, after 100 pages the fee will be .10 cents per page.
3. I understand and authorize the release of any records regarding drug, alcohol, or mental health treatment to the designated party listed above.
4. I understand that my treatment will not be affected if I do not sign this Authorization.
5. I understand that I may revoke this Authorization at any time by notifying the NeuroDevelopment Center, Inc **in writing**; however, if I do revoke the Authorization, it will not have any influence on any actions taken in reliance upon this Authorization by the NeuroDevelopment Center, Inc. prior to the receipt of the revocation.
6. I understand that this Authorization is effective for the lifetime of the patient, unless revoked (see #5).

Please note in order for our office to complete this request in a timely manner please be sure all information is completely and accurately filled out.

____ ____________________

Signature of patient or patient's Authorized Representative **Date**

The NeuroDevelopment Center
245 Waterman Street, Suite 200 Providence RI 02906
575 Mount Auburn Street, Suite B-102 Cambridge MA 02138

NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.

- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice, and releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1)we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

▪ **Child Abuse:** If we have reasonable cause to know or suspect that any child has been abused or neglected, as defined below, or is a victim of sexual abuse by another child, we must, within 24 hours, transfer that information to the Rhode Island Department of Child, Youth and Families, or its agent.

Child abuse and/or neglect is defined as a child whose physical or mental health or welfare is harmed, or threatened with harm when his or her parent or other person responsible for his or her welfare:

1) Inflicts, or allows to be inflicted physical or mental injury;
2) Creates or allows to be created a substantial risk of physical or mental injury;
3) Commits or allows to be committed an act of sexual abuse, sexual assault against, or exploitation of the child;
4) Fails to supply the child with adequate food, clothing, shelter or medical care;
5) Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his or her unwillingness or inability to do so; and abandons or deserts the child.

• **Health Oversight:** If a complaint is filed against us with the Rhode Island Board of Psychology, the Administrator of Professional Regulation (of the Division of Health) has the authority to subpoena confidential mental health information from us relevant to that complaint.

• **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we provided to you and the records thereof, such information is privileged under state law, and we will not release this information without: 1) written authorization by you or your legal representative; or 2) a subpoena of which you have received official notification and you have failed to inform us that you are opposing the subpoena; or 3) a court order. The privilege does not apply when you are being evaluated 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:** We may release your confidential health care information to appropriate law enforcement personnel, or to a person if we believe that person or their family to be in danger from you.

• **Workers' Compensation**: If you file a worker's compensation claim, we must release your relevant mental health care information for the proceedings.

• **Other:** When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *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 us. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.* You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- *Right to Be Notified if There is a Breach of Your Unsecured PHI*. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a revised notice in person at the time of your visit.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Office Manager of The NeuroDevelopment Center at (401) 351-7779 for further

information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The office manager can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.
We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in person at the time of your visit.

The NeuroDevelopment Center

Acknowledgement of Receipt of Privacy Practices

I, ______________________________, have received a copy of The NeuroDevelopment Center's Notice of Privacy Practices with an effective date of April 14, 2003.

_______________________________ ____________________
Name of Patient (please print) DOB

_______________________________ ____________________
Signature of Patient and/or Representative Date

****
Declines to Sign Acknowledgment of Receipt of Privacy Practices

_______________________________ _____________________
Name of Patient/Patient Representative DOB

The above named patient and/or representative has received a copy of The NeuroDevelopment Center's Privacy Notice but declines to sign acknowledgment.

Reason:
____

___________________________________ ____________________
Signature of Witness Date