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

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICE FORM

Rev. 02/12

____

PRINTED NAME OF PATIENT/GUARDIAN

____

SIGNATURE OF PATIENT/GUARDIAN

____

DATE

385 Imperial Highway · Fullerton, CA 92835
(714) 681-9070 · FAX (714) 773-4788

Service Agmt - Provider Copy

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

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____

SIGNATURE OF PATIENT/GUARDIAN

____

DATE

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If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless the psychologist determines that their involvement would be inappropriate. A patient over age 12 may consent to psychological services if he or she is mature enough to participate intelligently in such services, and the minor patient either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse. In addition, patients over age 12 may consent to alcohol and drug treatment in some circumstances. However, unemancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the patient, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement, is also essential, it is usually my policy to request an agreement with minors [over age 12] and their parents about access to information. This agreement provides that during treatment, I will provide parents with only with general information about the progress of the treatment, and the patient's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a workers compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the workers compensation insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have knowledge of a child under 18 or I reasonably suspect that a child under 18 that I have observed has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency, usually the county welfare department. I also may make a report if I know or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well being is endangered in any other way (other than physical or sexual abuse, or neglect). Once such a report is filed, I may be required to provide additional information.

- If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he or she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.

- If I have reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to him or her, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I also have a contract with a professional medical biller. As required by HIPAA, I have a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the name of this business.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state

PSYCHOLOGIST-PATIENT SERVICES AGREEMENT
[CALIFORNIA]

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I 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 we talk about both during our 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 many benefits. 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.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our 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 me. 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 my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-50 minute session (one appointment hour of 45-50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call by my next business day, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If you have a non-emergency situation that can not wait until the next business day, please call the St. Jude Medical Center Nurse advice line (800) 870-7537.

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I have read, understand, and agree to comply with the above information.

Signature of Patient/Guardian

Printed Name

Date

Billing Policy

CO-PAYMENTS AND/OR DEDUCTIBLE BALANCES WILL BE COLLECTED AT THE TIME OF SERVICE. Co-payments and deductibles are the responsibility of the patient. Extended unpaid balances for deductibles and/or co-payments will be forwarded to our collection agency. However we are not responsible for following up with the insurance company to ensure that they provide reimbursement, this is the patient's responsibility.

Patients with insurance plans that require prior authorizations: **Prior authorization must be on file in writing prior to all scheduled appointments.** While our front office will attempt to obtain all authorizations prior to your appointment, it would be helpful and possibly expedite the process if you contact your referring party for insurance authorization.

By signing this form, you are certifying that you are eligible with the insurance company listed on the card you presented at the time of your appointment. "I, the patient, understand that if the above is not true or if I am not eligible under the terms of my Medical and Subscriber Agreement, I am liable for any and all charges for services rendered.

No Show/Late Cancellation Policy: Patients who do not show up for a scheduled office appointment, or who do not cancel the appointment 24 hours in advance, will be charged a $100 fee. Any checks returned to us by the bank will be subject to a $25.00 fee.

A patient will be considered a cash patient once the account has been sent to collection due to a delinquent balance. *Any future services, after a patient has been sent to collections, will be paid at the time of service*. The patient will be responsible for any extraordinary costs associated with collection of funds owed to the practice, including but not limited to, collection agency fees, attorney's fees and court costs.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our front office to arrange how to see your records.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our front office. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the front office.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our front office and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies please let the front office know.

I have read and understand the above Notice of Privacy Practice .

____

Signature

____

Date

Fullerton Neuropsychological Services

CLINICAL PSYCHOLOGY & NEUROPSYCHOLOGY

Notice of Privacy Practices

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our front office staff about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

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Fullerton Neuropsychological Services

CLINICAL PSYCHOLOGY & NEUROPSYCHOLOGY

AUTHORIZATION FOR PAYMENT

Name of Patient:____

Name of insurance company:____________________________________

Subscribers name:__________________ Subscribers Number:__________

Policy Number:________________ Group Number:____________________

Phone Number:________________ Medicare Number:__________________

Billing Address:____

****

Secondary Insurance:____

Subscribers Name:__________________ Subscribers Number:__________

Policy Number:________________ Group Number:____________________

Phone Number:____

Billing Address:____

****

I hereby authorize the named insurance company or companies for full payment to Fullerton Neuropsychological Services, or any contracted or employed psychologist which may be directly under said corporation. I authorize full medical expense benefits allowable, and otherwise payable to you under my insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay in a current manner, any balance of said professional services charged over and above this insurance payment any co-pays, deductibles, or denied amounts.

Date:__________________Signature:______________________________

Assignment of benefits:
I hereby authorize Fullerton Neuropsychological Services to furnish information to insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for psychological services rendered and all Major Medical Benefits. A copy shall be as valid as the original.

Date:__________________Signature:______________________________

I UNDERSTAND THAT ALL APPOINTMENTS MUST BE CANCELLED 24 HOURS IN ADVANCE. IF I DO NOT CANCEL WITHIN 24 HOURS, I WILL BE PERSONALLY CHARGED A LATE CANCELLATION FEE OF $100. FOR MISSED APPOINTMENTS, I WILL BE PERSONALLY CHARGED A NO SHOW FEE OF $100.

Date:__________________Signature:______________________________

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Fullerton Neuropsychological Services

CLINICAL PSYCHOLOGY & NEUROPSYCHOLOGY

Patient Information

Name______________________________ SS#______________

Street Address______________________________________

City______________________State ______ Zip____________

Email Address______________________________________

Date of Birth ____________________ Gender: M ___F ____

Marital Status: S M W Sep D Spouse's Name______________________

Phone: Home__________________ Office/Cell__________________

Primary Care Physician________________ Phone:________________

May we contact your PCP? YES NO Referred By:________________

Emergency Contact__________________________________

Relationship ______________________Phone:________________

Patient Employer Information

Employer's Name__________________________ Phone:______________

Employer's Address__________________________________

City________________________State/Zip__________________

Patient's Occupation__________________________________

Insured Person (If Not Patient)

Name__________________________ Phone:________________

Street Address____________________ City/State________ Zip________

Subscriber's ID #__________________________Rel________________

Date of Birth____________________SS#____________________

Insurance

Primary Insurance Company ______________________________

ID#____

Group#______________________ Phone:____________________

Secondary Insurance Company Name________________________

ID#____

Group#______________________ Phone:____________________