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NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL TESTING INFORMED CONSENT

Welcome! You have most likely come to my office because you or your child are experiencing problems requiring further assessment. Please take a moment to read this form and ask for additional information or clarification.

Nature of My Services. I am licensed and trained to practice psychology in the state of California. I have a doctorate degree in clinical psychology from Pepperdine University. I additionally have extensive training in conducting psychological, psychoeducational, and neuropsychological assessments.

Assessment. Neuropsychological and psychological assessment includes a comprehensive evaluation of intellectual, academic, and/or emotional functioning. The evaluation will require direct contact, interviewing, and testing. I will also collect and review information from schools, psychologists, psychiatrists, and other professionals involved in your case. Depending on the number of tests being administered, we will typically meet on three or four occasions for 1 ½ to 4 hours each session. An appointment is a commitment to our work. If you need to cancel an appointment, please give me at least 24 business hours notice by telephone (**not email**). I will make every effort to re-schedule your cancelled appointment. Cancelled appointments will delay our work together and appointments not cancelled in advance will be billed at my hourly rate for each hour of our scheduled appointment time.

Foreseeable Risks and Discomforts. Some questions asked regarding yourself, your child, or your history may touch upon personal issues and uncomfortable

situations. I am not attempting to cause discomfort, but such questions are needed to obtain a comprehensive history and understanding as to the nature of your/your child's difficulties. By agreeing to participate in this evaluation, you are agreeing to cooperate to the best of your ability. In addition to distress, some individuals do experience fatigue and headaches following lengthier testing sessions.

Fees. My testing fee includes time spent on the intake interview, test administration, scoring, interpretation, report writing, consultation with other professionals involved in the case, and feedback. We will work together to set up a payment schedule. You are fully responsible for payment for these services. The process will most likely take three to four weeks. By the end of our time together, you will have better understanding of you or your child's difficulties, and you will be provided with an extensive written report and recommendations. You will also have an opportunity to ask any questions regarding the testing or testing results. Please note that your child is welcome to attend the final feedback session, if appropriate. Alternatively, you may schedule an additional feedback session for him/her to discuss these results with me in a manner more suitable to his/her developmental level. This additional feedback session will be billed at my hourly rate. According to law and ethics code, I have the right to turn over unpaid bills to a collection agency. If this should occur, I will provide you with the opportunity to pay and will notify you if I contact an agency. I will also charge in full for an appointment cancelled with less than 24 business hours notice (**i.e. not weekend days or holidays**). Cancellations must be made by telephone, not email.

INITIALS_____

Please note that I am not contracted with all insurance plans, and insurance coverage for testing is not guaranteed. I am an in-network provider for the following insurance plans: Cigna, Aetna, United, Magellan, Optum, and Medicare. I will make every attempt possible to obtain payment through your insurance company, however, should your insurance not provide coverage or payment for any services rendered, you are responsible for paying me directly at the contracted rate.

INITIALS_____

For out of network or cash pay services, I accept cash, credit card, and check. It is therefore customary to pay for all services at the time they are rendered. All checks should be made payable to Colleen Daniel, Psy.D. Returned checks are subject to a $25.00 service charge. You will be provided with a bill at the end of each session to enable you to bill your insurance company.

Please recognize that when insurance companies are used, there may be limits to confidentiality. Usually, insurance companies ask for information about duration of illness, psychiatric diagnosis, dates of service, name of treatment provider, treatment goals, and the details of the treatment session. In addition, providers are now required to sign waivers that allow the company to audit patient records. If I am subpoenaed or otherwise required to participate in a legal processing as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony. This will be billed at twice my regular rate. Similarly, school observations or consultation out of the office is also billed at 1 ½ times my regular rate, including travel time.

INITIALS _____

Certain portions of assessment are not reimbursed by insurance companies and are therefore billed separately to you. There is a $75 materials fee to cover the costs of testing supplies, computerized assessments, and computerized data interpretation. This fee is due at the first appointment.

INITIALS_____

Confidentiality. It is important for you to know about my confidentiality policy. Confidentiality is vital to treatment progress. In general, according to the law and my ethics code, what you and your child discuss with me is not shared with anyone else without your written permission. However, there are several exceptions, which are designed for your protection and safety. These exceptions include:

1) If you or your child is a victim of child abuse, or if you or your child divulges information about such abuse, I am required by law to report this to the appropriate authorities. Abuse includes, but is not limited to, physical, sexual, and emotional abuse.

2) If you or your child is a victim or perpetrator of elder or dependent adult abuse, or if you or your child divulges information about such abuse, I am required by law to report this to Adult Protective Services or other appropriate authorities.

3) If you or your child threatens harm to yourself, someone else, or the property of others, I may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm.

4) If ordered by the court, I may have to testify or release your records.

5) Per Section 215 of the Patriot Act of 2001, I may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law I cannot reveal when I have disclosed such information to the government.

I may also consult with another professional from time to time, but without identification of the patient whose case is the subject of consultation. Please also note that in the case of separation or divorce, I do not keep secrets from either parent and will need to share all information with both parents (assuming joint custody).

Maintenance of Records. Records of this evaluation will be held and maintained in accordance with California law. All information will be kept confidential as required by CA Welfare and Institution Code 5328.

Emergency Procedures. If you need to contact Dr. Daniel, you may call (657) 223-1690 and leave a message. Dr.Daniel checks messages on a regular basis and your call will be returned as soon as possible. In a life-threatening emergency, please call 911 or go to the nearest emergency room. You may also contact your community crisis hotline.

I look forward to working closely with you.

I have read and understood the information and policies described in this form. I have also been given the opportunity to ask questions, and have had my questions answered. I hereby agree to this psychological evaluation with Dr. Colleen Daniel, and to cooperate to the best of my ability, as shown by my signature below.

Signature of Patient: _____

Printed Name: _____

Date: _____

Signature of Guardian for minor patients: _____

Printed Name: _____

Date: _____

Witness, Colleen Daniel, Psy.D._____

Date: _____

No-Show/Late Cancellation Policy

I understand that failure to show up for my (or my child's) scheduled appointment with provider Dr. Colleen Daniel will result in my being charged the full hourly rate of $200. For appointments over 60 minutes in duration, I will be charged for the full amount of time scheduled.

I understand that failure to cancel my (or my child's) appointment by 3pm one business day before my scheduled appointment (or by Friday at 3pm for Monday appointments) will result in my being charged her full hourly rate of $200/hour.

I understand that all no-show fees will be billed to the credit card I have on file with Dr. Daniel unless alternative payment arrangements are made.

I understand that no show/late cancellation fees are **not** covered by my health insurance, and that I am responsible for paying all late and no-show fees for myself or child.

I understand that I need to contact the office at (657)223-1690 to cancel or reschedule appointments.

Patient Name:_____

Patient or Parent/Guardian Signature:_____

Date:_____

Electronic Communication Policy*

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that

occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

I have read and understand Dr. Daniel's electronic communication policy.

Signed:_____

Printed Name: _____ Date: _____