Triad Neuropsychology and Forensic Services, PLLC
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Welcome! This document contains important information about professional services and business policies at Triad Neuropsychology and Forensic Services, PLLC. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA) and the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. Please read this document carefully and thoroughly. By initialing and signing this document, you are agreeing to all provisions within. You may revoke your agreement in writing at any time.

The Assessment Process:

Psychological/Neuropsychological testing involves a thorough assessment of a patient's cognitive (thinking) abilities with the use of short, standardized, and functional tests. The results of an evaluation provide a pattern of strengths and weaknesses that help us understand possible causes of change in thinking abilities. Evaluations can help establish a baseline, differentiate between illnesses/disorders that have similar clinical presentations, and help establish treatment plans. The results are then shared with you and your referring provider to help guide planning for future care. The assessment process is typically broken into four parts:

Intake Meeting: The psychologist will conduct an intake interview with the patient (and family/guardians as appropriate) to learn more about the patient and explain the diagnostic evaluation process. This usually takes place virtually via HIPAA-compliant videoconference platform, though this may occur in person, depending on the presenting referral question.

Testing Appointment(s): Testing appointments will be conducted in person either with the psychologist or a psychometrist (assistant trained in the administration of psychological/neuropsychological tests). Various areas of cognition will be assessed, including language, visuospatial, attention/processing speed, memory, executive functioning, mood, and personality. While we make every attempt to be as efficient as possible, we also want to prioritize the individual's well-being and ensure that we are capturing the individual's optimal level of functioning. As such, testing may occur over the course of multiple appointments, depending on the presenting concern and at the discretion of the psychologist.

Scoring and Analysis: After the test administration, the psychologist will score, analyze, and interpret the assessment results. The psychologist takes into account the unique client presentation, assessment findings, historical and current context, and often consults with additional members of the patient's family and other treating providers (e.g., spouse, parents, therapist, PCP, etc.).

Feedback meeting: During the feedback meeting, which is usually virtual, the psychologist will present the findings of the evaluation, conclusions, and recommendations for next steps. A report is written summarizing this information and is provided to the patient/family after the conclusion of the feedback session.

Authorization Regarding Personal Health Information and Confidentiality:

All communication between the patient and Triad Neuropsychology and Forensic Services, PLLC becomes part of the clinical record. Records are the property of Triad Neuropsychology and Forensic Services, PLLC. In compliance with North Carolina regulations [N.C. Gen. Stat. § 90-270.15(a)(18)], patient records are kept for seven years from the date of the last provision of psychological services, or three years from the date of the attainment of majority (whichever is longer) before being shredded and disposed of. While most communication between the patient and psychologist is confidential, the following limitations and exceptions exist:

1. The psychologist determines that the patient is a danger to themselves or to someone else.
2. The patient discloses abuse, neglect, or exploitation of a child, elderly person, or disabled person.
3. The patient authorizes the psychologist to release records.
4. The referral source requests the release of records.
5. The patient has a medical emergency while at this practice.
6. The psychologist is mandated to disclose information by law enforcement agencies, to a coroner/medical examiner, by Public Health offices relating to diseases or FDA-regulated products, for specialized government functions (e.g., fitness for military duty, VA benefits, and/or national security issues), or to a health oversight committee (e.g., the U.S. Department of Health and Human Services).

You have the following rights regarding personal health information (PHI) that is maintained by this practice about you. To exercise these rights, please submit your request in writing to the practice owner.

1. Right of Access to Inspect and Copy – You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set," which contains mental health/medical and billing records and any other records that are used to make decisions about your care. This right is only restricted in situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained clinical notes. We may charge a reasonable, cost-based fee for copies. You also have the right to request an electronic copy of your PHI if it is maintained in an electronic format. You may also request that a copy of your PHI be provided to another person.

2. Right to Amend – If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend it – although we are not required to agree to this amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the practice owner if you have any questions.

3. Right to Request Restrictions – You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request, unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care service that you paid for out of pocket.

4. Right to an Accounting of Disclosures – You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

5. Right to Request Confidential Communication – Normally, we send information related to your healthcare to the address and phone numbers you have provided. However, you have the right to request that your healthcare information be sent to an alternative address to protect confidentiality.

Please initial next to the following statements to express understanding and agreement to the terms listed below:

_____ (initials) I acknowledge that I have read and received a copy of the privacy policies and procedures.

_____ (initials) I understand and agree to the limits of confidentiality detailed in this document.

Telehealth Informed Consent:

Telehealth involves the use of electronic communications to enable Triad Neuropsychology and Forensic Services, PLLC clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. You have the following rights with respect to telehealth services:

1. The laws that protect the confidentiality of personal information also apply to telehealth. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

2. You have the right to withhold or withdraw consent to the use of telehealth during your care at any time, without affecting your right to future care or treatment.

3. Some services are provided by technology (including but not limited to video, phone, text, apps, and email) and may not involve direct face-to-face communication. There are risks and consequences related to telehealth, including but not limited to the possibility that transmission of any personal information could be disrupted or distorted by technical failures, the transmission of personal information could be interrupted by unauthorized persons, and/or the electronic storage of personal information could be unintentionally lost or accessed

by unauthorized persons. Triad Neuropsychology and Forensic Services, PLLC utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth.

4. It is the patient's responsibility to maintain privacy on the patient's end of communication. Other parties authorized by the patient and those permitted by law may also have access to records or communications.

5. Triad Neuropsychology and Forensic Services, PLLC follows the state of North Carolina regulations for telehealth, as well as the appropriate licensing board regulations and ethics code. Training about the provision of telehealth services has also been completed.

6. Certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based services. If you are in crisis or in an emergency, you should immediately call 911 or seek help from a local hospital or crisis-oriented health care facility in my immediate area. Some options include:

    a. Wake County Mobile Crisis: 877-626-1772
    b. Wake Behavioral Health Urgent Care: 919-703-2845
    c. Duke Behavioral Health North Durham: 919-684-0100
    d. Cone Behavioral Health at Alamance Regional Hospital: 336-832-9700

Please initial next to the following statements to express understanding and agreement to the terms listed below:

_____ (initials) I will ensure I have a private location to engage in telehealth services.

_____ (initials) I will not attempt to engage in telehealth services while driving.

_____ (initials) I will not consume any alcohol or illicit substances before or during any session.

_____ (initials) If the patient is a minor, a parent/guardian 18+ will be in the same building as the patient, unless otherwise agreed upon by the clinician and parent/guardian.

Fees and Payment Policy:

Triad Neuropsychology and Forensic Services, PLLC does not participate on insurance panels and is considered an Out-of-Network (OON) provider/practice. We are happy to provide a superbill (invoice) summarizing all services for you to submit to your insurance company for reimbursement of Out-Of-Network (OON) benefits; however, we will not collect or accept any payments from your insurance company. A separate fee schedule is available for all clinical services.

Payment for clinical services is required before the service will be provided. A deposit is required at the time of scheduling ($1,000) and is applied to your final balance. The remaining balance is due two business days before the testing appointment. *If full payment is not received by two business days before the scheduled appointment, Triad Neuropsychology and Forensic Services, PLLC reserves the*

right to cancel that appointment and any future appointments as applicable. Reasonable efforts will be made to reschedule missed appointments within a short timeframe; however, this is not guaranteed, and your appointment may be scheduled for the next available opening.

All missed appointments and those that are cancelled with less than two business days' notice are subject to a non-refundable fee ($100 for any intake or feedback appointments and $500 for any testing appointments). Should you choose not to reschedule, the applicable fee will be deducted from your deposit and the balance will be promptly refunded. If you do choose to reschedule, the applicable fee must be paid in full before rescheduling occurs; please note that these fees are in additional to the total amount charged for your evaluation. For example, if your evaluation costs $2,500 and you accrue a $100 late/no show fee, your total owed will be $2,600.

Payment via check is strongly preferred to avoid rising credit card fees. All checks can be mailed to P.O. Box 8, Mebane NC 27302. Payment via credit card or HSA/FSA card is also accepted. Regardless of payment method, valid credit card information must be kept on file in case no-show/late cancel fees are accrued. If these charges apply, you are welcome to pay them via check; however, if no contact is made within five business days of the missed appointment, the credit card on file will be charged for the applicable amount.

No refunds will be given if you disagree with the results or outcome of the evaluation. You are welcome to seek a second opinion and the psychologist can provide referrals as needed. There are no exceptions to this policy.

Please initial next to the following statements to express understanding and agreement to the terms listed below:

_____ (initials) I understand and agree I am responsible for notifying the practice no more than two business days prior to the scheduled appointment if I need to cancel/reschedule.

_____ (initials) I understand and agree that a non-refundable fee of $100 for intake/feedback appointments and $500 for testing appointments will apply and require payment in full before any appointment is rescheduled.

_____ (initials) I understand and agree that valid credit card information must be kept on file and updated appropriately should the details change (e.g., expiration date). This card will be charged automatically if a patient is unreachable and a non-refundable fee is assessed.

_____ (initials) I understand and agree that payment in full is expected regardless of outcome and that no guarantees are made about the results of this evaluation.

No Surprises Act:

Effective January 1, 2022, the No Surprises Act was passed by the U.S. Congress as part of the Consolidated Appropriations Act of 2021. It is designed to protect clients from surprise bills for emergency services at OON facilities or providers, holding them liable only for in-network cost-sharing

amounts. The No Surprises Act also enables uninsured patients to receive a good faith estimate of the cost of care.

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. This is not a final bill or an agreement of total cost, and the total cost may change slightly as the evaluation progresses. Your clinician will discuss any potential costs in advance before proceeding further and update the Good Faith Estimate as appropriate. If you receive a bill that is at least $400 more than the provided estimate, you can dispute the bill. For additional information, please visit the U.S. Centers for Medicare and Medicaid Services (CMS) at www.cms/gov/nosurprises/.

Please initial next to the following statements to express understanding and agreement to the terms listed below:

_____ (initials) I understand and agree that I am entitled to a Good Faith Estimate prior to paying for clinical services.

Final Signature Page

I have read and understand the information provided in this document regarding the assessment process, my rights to privacy and confidentiality, fees and payment policies, and the use of telehealth. By my signing below, I hereby give my informed consent and state that I have read, understood, and agree to the terms of this document:

_____ _____

Signature of patient/legal representative Date

Name of Patient (Printed): _____

Name of Legal Representative/Relation (if applicable): _____

Credit Card Information

**Card will only be charged in accordance with the provisions listed in this document.

Type of Card: ☐ Visa/Mastercard ☐ Discover ☐ American Express ☐ HSA/FSA

☐ Other: _____

Name on Card: _____

Card Number: _____ Card Expiration (MM/YY): _____

Card CVV: _____ Billing Zip Code: _____