Spader Psychological Services, LLC
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Informed Consent for Participation in Psychological Services

Hello, and welcome to my practice. Please read this document carefully because it contains important information about my business, office policies, and psychological practices. If you have questions, please write them down and ask me at your first meeting. When you sign this form, it represents a contract between us. You will be given a copy of this form if you wish. **Please initial each page after you have read the contents**.

Name of Patient: _____

If applicable, Name of Parent/Legal Guardian: _____

Types of Services Provided: At your initial visit/intake session, you/your child will be interviewed about life history, current situation, what brings you in for services, and the goals you have for therapy/assessment. You may also be asked to fill out some questionnaires to assist me in understanding how to best help you. Diagnostic Intake visits typically last 60-75 minutes, sometimes less.

We may decide the best way to help you is through psychological assessment/testing and/or psychological treatment. Psychological testing involves exploration of diagnostic possibilities. *Particular diagnostic outcomes cannot be guaranteed and do not always match the initial concerns discussed so please remain open to various possibilities.* Appointments can last anywhere from one to several hours depending on the age of the patient, presenting concerns, attention, and behavior during testing. I will attempt to complete all testing in one session, whenever possible. Rating forms are also given to parents and teachers when needed. A feedback session, typically lasting 50-60 minutes, will be scheduled to review results and recommendations of testing in detail. A Psychological Assessment Results report will be provided to you at the conclusion of testing. Treatment/intervention sessions typically last 50-60 minutes, and parental involvement for children/adolescents will be required. Treatment will often involve work/tasks/activities for you/your child to complete prior to the next session. The number of treatment sessions needed is different for everyone and difficult to estimate. Throughout treatment we will assess progress towards your goals and revise goals as needed. If you are dissatisfied with testing or treatment at any time, please discuss this with me so that we can try to address your concerns. I will make a referral to another therapist if necessary and/or at your request, but I am not responsible for care received from professionals to whom I refer you. It is your right to discontinue treatment at any time. Sometimes, when beginning or throughout treatment, people experience a temporary increase in their distress because the process of addressing and clarifying personal issues can be difficult or painful. On the other hand, treatment has been shown to be beneficial for those who participate, although there can be no guarantee as to your response to treatment.

Billing and Insurance: You have the right to use insurance benefits to cover your services with me if you have an insurance carrier that I accept (i.e., for which I am an In Network provider) and your insurance plan provides benefits that cover my services for you and/or your child. Services may not be covered if you are not eligible for benefits with the insurance plan, you have exhausted all benefits for the service(s), services requested are not covered under the plan, and/or services requested do not/no longer meet medical necessity as determined by the plan. Please note the following:

- It is important that you contact your insurance company in order to fully understand your outpatient mental health benefits such as what services are covered, how many hours are covered, if an authorization/pre-authorization is needed, and if you have a copay/coinsurance/deductible. The Testing Authorization Checklist on my website can assist in your inquiry (www.spaderpsychology.com, see Forms page).
- Quotes obtained from insurance companies, either by yourself, me, and/or my billing service, are not a guarantee of coverage/payment.

- When using insurance, I must make a formal diagnosis that will, to the best of my knowledge, be a part of you/your child's record. Also, your insurance carrier may require me to send confidential patient information in order to authorize treatment or reimbursement.
- *Some* insurance plans do not cover particular diagnoses such as learning disabilities and/or autism spectrum disorder. Insurance plans do not cover testing specifically for giftedness.
- Should your insurance company refuse payment for services, you will be held responsible for paying the amount in full (see Fees for Services below) or as allowable by the contract I have with your insurance company.
- As a courtesy service to you, I or my billing service will file claims to your insurance company, but it is your bill and your responsibility to make sure that your bill is paid in full.
- Payment related to copayment/coinsurance and/or deductibles will be required at the time of service.
- The parent/guardian bringing a child in for services is responsible for paying any fees associated with that day's appointment regardless of which parent/guardian the insurance policy is under.
- If your insurance refuses to pay for services, payment of fees will be due at the time in which I receive the Explanation of Benefits from your insurance company.

Please initial to indicate your understanding of these insurance-related considerations ___.

If you prefer to not use insurance benefits, payment of fees will be due at the time of service (see Fees below). You may also use Out of Network benefits if your plan covers this but I will collect the full session fee at the time of service; I can give you an invoice so that you can seek reimbursement from your insurance.

Fees for Services:

Initial Visit/Diagnostic Intake $240

Each hour of **Diagnostic/Psychological Testing** $160

**These services include time spent administering the tests as well as the additional time required for scoring, analyzing, and interpreting the results as well as writing the Psychological Assessment results report.

Session of **Therapy/Intervention**

16-37 minutes $120

38-52 minutes $160

53+ minutes $200

**Therapy/intervention services typically require 53+ minutes.

<u>Additional Services/Fees</u>

$35 per 15 minutes (billed to you as insurance will not cover/pay)

-Phone calls lasting more than 10 minutes

-Written letters/reports requiring more than 10 minutes

-Medical records preparation/sending to another treating provider requiring more than 10 minutes

If you become involved in a legal proceeding that requires my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $300 per hour for activities such as testifying in court or deposition as well as court-related preparation and travel time. The timing of court proceedings is unpredictable so you will likely have to pay for a full day of time on the date of court as I will need to block my full day's schedule. Payment will be due prior to my participation.

Cancellation Policy: I take great care to avoid being late for any patient. Consequently, if you arrive more than 15 minutes late for an appointment, I may not be able to see you on that day (although I will make every effort). If I have to cancel an appointment due to illness or emergency, please know that I do so to protect you and your child from my illness, or I am experiencing a personal matter that requires my immediate attention. You will be offered my next available appointment where I will make every effort to accommodate your availability. You

may cancel an appointment at any time by calling me at (614) 852-4152, emailing contact@spaderpsychology.com, or using therapyappointment.com. If you miss an appointment without canceling at least 48 hours in advance, unless we both agree that you were unable to attend due to circumstances beyond your control, you will be charged $50 for a missed Treatment or Feedback appointment and $50 per hour that was scheduled for a Testing session (Testing incurs a greater charge as I have set aside 2-3 hours of my schedule for your appointment). Insurance companies will not cover/pay this fee so you will be billed. **Please initial to indicate your understanding of this fee ___**. If you are unable to give 48 hours' notice, call as soon as you can because if I can fill your appointment time I will not charge you the cancellation fee.

Contacting Dr. Spader-Cloud & Emergencies: I am usually not immediately available. While I am typically in my office Monday through Wednesday (except for holidays), I do not answer the phone while I am with a patient. Please leave a voicemail at (614) 852-4152 or email contact@spaderpsychology.com (both services are HIPAA-compliant although I make no guarantee regarding the security of the services; **please initial to indicate your understanding that Dr. Spader-Cloud cannot guarantee the security of email communication ___**), and I will return your communication within 3-4 business days. Email should never be used for emergency situations. There will be little to no discussion of treatment-related matters via phone/email; please schedule an appointment to discuss such matters. If you experience an emergency and cannot reach me, please call your family doctor, 911, Netcare Access at (614) 276-CARE, or go to the nearest emergency room. If I will be unavailable for an extended period of time, we will discuss what coverage options you would like, and I will give you the name of another therapist to contact if you wish. With regard to social media, I do not accept "friend" or contact requests from current or former patients on social networking sites (Facebook, LinkedIn, etc).

Confidentiality and Disclosure: Your patient information is always held confidential in accordance with both legal and ethical standards. This information includes patient appointments, session notes, test results, written reports, demographic information, and financial information. Please review the Notice of Privacy Practices as it gives detailed information regarding the protection of your private healthcare information (PHI) and how it may be shared. I may ask you to sign release of information forms for me to communicate with other professionals to coordinate you/your child's care; you have the right to refuse to sign these forms if you so choose. Additionally, I may seek consultation from colleagues regarding your care, but no identifying information will be shared. If I see you in public, I will not acknowledge your presence so as to not break your confidentiality, but I will respond if you greet me first. Please be aware that there are certain circumstances in which I am required by law to breach patient confidentiality. These circumstances include:

- If I believe that a patient is a danger to him/herself or others
- If I believe that an individual is the victim of child/elder/disabled adult abuse or neglect (I am a mandated reporter)
- Court mandated subpoenas
- Your insurance carrier may require confidential patient information in order to authorize treatment or reimbursement

When working with a minor, the confidentiality of the minor is important in order to have an effective therapeutic relationship. I will speak with parents to try and ensure that minors experience the same degree of confidentiality as adults. However, parents do have the legal right to examine a minor's treatment records. Please note that any parent/legal guardian has rights to the information specifically pertaining to a child held within a child's treatment records unless there is a court document stating otherwise.

Professional Records: The laws and standards of my profession require that I maintain treatment records. Information discussed during sessions/visits, on the phone, and via email all become part of your professional record. You are entitled to receive a copy of you/your child's records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to read. If you wish to see your/your child's records, I recommend that you review them with me so that we can discuss the contents.

Release of Liability: You release me of liability for your psychological care in the following situations: if you/your child fails to show for an appointment and I do not hear from you within one week of that missed appointment, and if you cancel an appointment without rescheduling,. You are welcome to reschedule at any time, provided that any past balances (including missed appointment fees) are paid. Failing to show and/or failing to provide 48 hours' cancellation notice 2 times in a row or 3 times within a 3 month period may result in termination of psychological services with me and resultant release of liability. Any other justifiable reason for the termination by me of your psychological services with me will also result in a release of me from liability for your psychological care. If there are extenuating circumstances, such as family emergencies or sudden business trips, please contact me as soon as possible to inform me.

Please initial one of the statements below (or indicate N/A if you will be private pay/self-pay):
_____ I do NOT authorize release of any information about me/my child to an insurance company. I will be responsible to pay all fees for treatment myself (Please complete Private Pay Agreement).

_____ I authorize my psychologist to act as my agent in helping me obtain payment from my insurance carrier(s). I, therefore, authorize my psychologist to release information about me/my child as necessary to her billing service and my insurance company for billing purposes. I authorize payment of benefits to Spader Psychological Services, LLC for services provided.

Agreement: Your signature below indicates the following:

- I have read the information in this Informed Consent for Participation in Treatment and agree to abide by its terms during our professional relationship.
- I consent for treatment by authorizing Michelle Spader-Cloud, PsyD, BCBA-D to provide psychological testing or treatment services me or my dependent child or adult.
- I understand that I am financially responsible for any balance or copay/coinsurance not covered by insurance.
- I am aware that Dr. Spader-Cloud is not responsible for any personal property or valuables I bring into her office.
- I have reviewed the Notice of Privacy Practices (available on Dr. Spader-Cloud's website or on paper if I request).
- I consent to _____ Email _____ Text (check any/all that apply) for appointment reminders.

_____ _____
Name of Patient (please print) Patient's Date of Birth

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Relationship to Patient