BRUNETTI CONSULTING, INC.
Psychological Services

Legal name:_____ Preferred Name: _____

Birthdate:_____ Age: _____ Gender: _____

Address:_____
STREET CITY STATE ZIP

Parent/Guardian Names: _____

Phone #: Home: _____ Parent Mobile:_____

School Attending: _____ Current Grade: _____

Primary Care Clinic: _____ Primary Physician: _____

Current medications: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relationship_____

Address:_____ Phone:_____

RESPONSIBLE PARTY:
Name of person responsible for the account: _____

Address: _____
STREET CITY STATE ZIP

Phone Number: _____

BILLING POLICY:
COPAYMENTS, DEDUCTIBLES AND ANY FEES FOR SERVICES NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We ask that copayments and deductibles be paid at the time of service unless other arrangements are made. Monthly bills will be sent if payment is owed on your account.

FEES FOR SERVICE:
Neuropsychological/Psychological Testing: $250.00 Per Hour
Psychotherapy Fees: Initial Appointment: $300.00; Individual Psychotherapy: $200.00; Missed Appointment without 24 hour notice: $50.00

(PLEASE COMPLETE REVERSE SIDE)

CONSENT TO RELEASE/EXCHANGE INFORMATION:

- The information gathered during this evaluation/treatment is considered Protected Health Information (PHI). I have been provided access to and agree with the written policies regarding how my PHI can be used.
- I have been provided with access to and agree with the Notice of policies and practices of Brunetti Consulting, Inc.
- I authorize any release of information as required by my insurance company, QRC, or doctor to process my claim. I permit a copy of this authorization to be used in place of the original. This information may include, but is not limited to: Place of service, diagnosis, type of treatment, medical background and relevant history, and information about treatment. I understand that in most cases the insurance company requires case notes or a written summary of my treatment. This information will be provided to my insurance company.
- I authorize Brunetti Consulting, Inc. to be paid directly by my insurance carrier. I consent to allow Brunetti Consulting, Inc. to process by billing form electronically (if unacceptable, patient agrees to pay directly and remit claim independently).
- I authorize the business office to release billing information or date of service to the following individuals (list the name(s) of any individual other than yourself who may be allowed to receive this information, such as a noncustodial parent) _____

SIGNATURE _____DATE _____

BRUNETTI CONSULTING, INC.

Psychological Services

CONSENT TO TREAT

I _____ give permission
(parent or guardian)

for _____ _____ to receive
(name of patient) (date of birth)

psychological testing/psychotherapy at Brunetti Consulting, Inc.

_____ _____
(parent/guardian signature) (date)

_____
(printed name of parent/guardian)

21308 John Milless Drive, Suite 101B
Rogers, MN 55374
Phone: (763) 428-4060
Fax: (763) 428-1711

BRUNETTI CONSULTING, INC.
Psychological Services

Notice of Policies and Practices – Including Protection of the Privacy of Your Health Information

You should be aware that I keep protected healthcare information (PHI) about you in your Clinical Record. It includes information about your reasons for seeking psychological services, a description of the impact of your symptoms on your life, your diagnosis, your medical and social history, your treatment history, records received from other health care providers, reports of professional consultations, your billing records, and reports that have been sent to others, including your insurance carrier. Below are our policies and practices to ensure confidentiality of your PHI, as established by the Healthcare Insurance Portability and Protection Act (HIPAA) and similar legislation. Limits of confidentiality and additional policies about payment and communication are included.

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

I may use or disclose your PHI for treatment, payment, and health care operation purposes with your consent. *PHI* refers to information in your health record that could identify you. *Use* applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing PHI. *Disclosure* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties. *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist. *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my 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.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *authorization* is written permission above and beyond the general PHI consent. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I 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 Disclosure with Neither Consent nor Authorization

If I have reason to believe a child or vulnerable adult is being or has been neglected or physically or sexually abused, I must immediately report the information to the local welfare agency. The Minnesota Board of Psychology may subpoena records from me if they are relevant to an investigation it is conducting. If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you, I must not release this information without written authorization from you or a court order. If you communicate a specific, serious threat of physical violence against an identified victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I also may disclose PHI necessary to protect you from a threat to commit suicide. If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Dept. of Labor and Industry or you will not need your prior approval. If any of the above situations arise, 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.

IV. Patient's Rights and Psychologists Duties

You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. You have the right to request to 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 me. On your request, I will send your bills or correspondence to another address. You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you. You have the right to request an amendment of PHI for as long as the PHI is maintained in the

record. You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically. If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, I encourage you to discuss your concerns with me. You may also send a written complaint to the Secretary of the US Department of Health and Human Services.

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes; however, I am required to abide by the terms currently in effect.

V. Billing and Payment

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. I have contracts with businesses that provide additional support services (e.g., billing). I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

VI. Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions regarding coverage, call your plan administrator. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes, I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. I have no control over what they do with your PHI once it has been released to them. I will provide you with a copy of any report I submit, if you request it in writing.

VII. Communication

I will communicate with you by phone, mail, and fax. Email is not a secure form of communication. At your request, I will send you forms that do not contain PHI and/or I can verify appointment times. I will not communicate results of your psychological evaluation or other parts of your Clinical Record over unsecured email. Additionally, I will not respond to requests for contact over social media (e.g., Facebook), texting, or other unsecured electronic methods.

VIII. Agreement

The law requires that I obtain your signature acknowledging that I have provided you with this information. Your signature stating you received this agreement will also represent an agreement between us. You may revoke this agreement in writing at any time. The revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. You should be aware that this agreement will be in effect for one year from the date of signing unless you specifically request that it remain in effect for a shorter time. This contract, or any provision of this contract, can be revoked by you at any time, except to the extent that I have relied on it.

This notice will go into effect on January 1, 2016. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person or by mail.