

Jennifer R. Blair, Ph.D.

Clinical Neuropsychologist

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Agreement and Notice

Welcome to my practice! I look forward to working with you and/or your child.

This document (the Agreement) contains important information about my professional services and business policies. In order to protect you and/or your child, the State of Washington requires that all clients of psychologists receive certain basic information. It also is important that you understand what a neuropsychological evaluation entails. Please read through the following information and sign the statement at the end saying that you have read and understand this, and that you agree to the conditions of the evaluation. (A teen between the ages of 13 and 17 years of age must consent to undergo evaluation by reading and signing this form along with his or her parents.)

This document also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of initial contact. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That 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.

Education, Training, and Licensure: Dr. Jennifer R. Blair is a Clinical Neuropsychologist licensed to practice psychology by the State of Washington Department of Health (#1782). She has a doctoral degree in Clinical Neuropsychology from the University of Victoria, British Columbia, and has passed the national written examination and the oral examination given by the Washington State Examining Board of Psychology. Neuropsychology is the field of psychology specializing in the relationship between the brain and cognition, or thinking abilities. Dr. Blair's doctoral training emphasized how brain systems are related to

the development of attention, perception, learning, memory, thinking, and behavior. Since earning her Ph.D., Dr. Blair has worked as a Clinical Neuropsychologist in private practice, a Research Professor and Lecturer at the University of Washington College of Education, and a Rehabilitation Psychologist at Children's Hospital and Regional Medical Center. Dr. Blair specializes in the assessment and remediation of traumatic brain injuries, learning disabilities, and other neurological disorders. She maintains her skills and keeps up-to-date with scientific advances by reading the scientific literature, attending workshops, and consulting with colleagues.

The Examining Board of Psychology regulates the practice of psychology in the State of Washington. If you have a problem you cannot resolve with Dr. Blair, or wish to file a complaint, you may do so by contacting the Department of Health, Examining Board of Psychology, P.O. Box 47868, Olympia, WA 98504-7868.

Your Rights and Responsibilities: You have the right to choose the psychologist that you want you or your child to see. You have the right to discontinue the evaluation process at any time, to request a change in the evaluation process, or to request a referral to another provider. (Should you discontinue the evaluation process, you will be expected to pay for those services already provided.) Your request for discontinuance or referral to another provider will not affect your future relationship with Dr. Blair. If you are age 13 or older, you have the right to refuse evaluation or treatment. Choosing a psychologist and type of service are important decisions. You are encouraged to ask questions about the psychologist or the types of evaluation or treatment suggested so that you can make the choices that best suit your needs.

Confidentiality: In order to protect your privacy, state law mandates that confidential information provided to a psychologist is protected from disclosure to others. In other words, information about you and your family will not be given to other people or agencies without your written consent with only a few exceptions. These are:

1. If a judge authorizes a court order requiring the disclosure of your records, the psychologist must, by law, comply by releasing the information to the court.
80410088. If the psychologist discovers abuse or neglect of a child or dependent adult, the psychologist is required by law to report detailed information to the Department of Social and Human Services.
80414552. If the psychologist determines that you are a danger to yourself or to others, the psychologist must try to prevent harm, even if that involves breaking your confidentiality.
80414553. If the psychologist determines that you are suffering from HIV-related illness and do not have a physician providing for your care, the psychologist must report the identities of your IV drug using or sexual partner(s) to the local health care officer (WAC 248-100-072).
80414554. As a result of new state regulations adopted by the Washington State Department of Health, I am required to report myself or another health care provider in the event of a final determination of an act of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have knowledge of unprofessional conduct by another licensed provider. I will also have to report a patient who is a health care provider who may pose a clear and present danger to his/her

patients, clients. If you have any questions or concerns about this requirement, please discuss them with me.

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. Please refer to the attached Notice for further information regarding confidentiality.

About the Evaluation Process: The first stage of the evaluation process involves collecting background information about the current problem. Along with this form, you should have received a Developmental History form for you to fill out. Please bring this completed form with you to the first appointment. The following information should also be brought to the first appointment, if applicable:

1. All prior psychological or educational test reports.

80414600. All report cards (i.e. progress reports) and a copy of the cumulative school record, dating from kindergarten. These records are usually available through the office of your child's current school.

80414680. Individual Education Plan records.

80518632. All relevant medical records.

The second stage of the evaluation process involves formal testing. Formal testing involves sitting at a table and performing school work, answering questions, looking at pictures, assembling puzzles, and other similar types of activities geared to the age of the child. There are no shots and no painful procedures. Some children are anxious about formal testing, but most find it tolerable and even enjoyable once they learn what it involves. A professional trained in test administration (psychometrist) and/or Dr. Blair will carry out the formal testing.

Preparing for the appointment helps to ensure the child's best performance. Glasses or hearing aids should be brought to the appointment fully operational. Please inform Dr. Blair beforehand if your child will be taking prescription medication when the testing is being performed. A full night's sleep and a good breakfast are simple, but important steps. Please bring a snack if the child is accustomed to one during the testing time. Let the child know about the appointment in terms they can understand. Older children who are aware of the current problem can understand that they will be seeing someone to help them with the problem. Younger children can be told that they will be working with a special teacher. Preschool children can be told that they will be playing games to show what they know.

The third stage of the evaluation process involves the interpretation and discussion of the results at the feedback session. If at all possible, it is important that both parents attend the feedback session in order to best convey the results and discuss recommendations.

Interested others, such as teachers and therapists, are welcome to attend if the parents (and older teen) agree. Preschool children usually should not attend the feedback session since they will not benefit from the discussion and may find it confusing. Arrangements will be made to provide feedback to older children and teens as best fits their circumstances. A written report will be prepared which describes the evaluation results, diagnosis, and recommendations.

In many cases, the recommended interventions can be carried out by those already working with the child (e.g. parents and teachers). Referral for additional services will be offered as needed. Depending upon the results of the evaluation, Dr. Blair may suggest that she provide additional services. These can include consultation with school personnel, consultation with other providers, cognitive therapy interventions, and behavior management interventions. Dr. Blair is available for additional feedback sessions or consultation with the parents on an ongoing basis if needed after the evaluation process is complete.

Professional Records: Dr. Blair keeps a record of the services provided. You may ask to see and copy that record. You may ask her to correct that record. She will not disclose your records to others unless you direct her to do so or unless the law authorizes or compels her to do so. Please refer to the attached Notice for further information regarding professional records.

Fees and Billing:

Neuropsychological and Psychoeducational Assessment: My hourly fee for the initial intake appointment is \$220. For the remainder of the assessment, including the formal testing, test scoring/interpretation, report writing, and feedback session, my fee is \$195 per hour. I also charge this amount on a pro-rated basis for other professional services, such as school conferences that you have authorized, or telephone calls lasting over 15 minutes. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, my hourly fees are higher. If this issue should arise, please ask for my fee structure with regard to legal proceedings.

The time estimated for this assessment is as follows:

_____ hour(s) intake session (\$220 per hour)
_____ hour(s) formal testing (\$195 per hour)
_____ hour(s) test scoring, interpretation, and report writing (\$195 per hour)
_____ hour(s) feedback session (\$195 per hour)

_____ total estimated hours; estimated cost =

One thousand dollars is due at the initial intake appointment, and the balance is due at the feedback session. Personal checks can be made payable to “Jennifer R. Blair, Ph.D., Inc.” Any ongoing monthly balances are charged a \$2.50 per month rebilling fee. Returned checks will be charged a \$25.00 handling fee. I accept Visa and MasterCard as a method of payment.

I am not contracted with any insurance companies, but I will generate a statement that you can submit to them for reimbursement. If you would like to submit claims to your insurance company, you will need to find out such information as whether or not you need a referral, number of sessions covered, types of problems covered, types of sessions or evaluations covered, and at what rate your insurance company will reimburse you for my services. I will

do everything I can to assist in this process, but **it is your responsibility to keep track of this information so that you receive appropriate reimbursement.**

Cognitive Rehabilitation and Psychotherapy: My hourly fee for follow-up services, such as cognitive rehabilitation and/or psychotherapy, is \$195. Fees for these services are due at each session.

Cancellation Policy: Your appointment time is set aside exclusively for you, and I cannot fill that time slot without sufficient notice. If you must cancel an appointment, please make sure that you get in touch with me at least **48 hours in advance** or you will be billed the full session fee (unless we both agree that the appointment was unable to be kept due to circumstances beyond your control).

HIPAA NOTICE

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

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

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

“*PHI*” refers to information in your health record that could identify you.

“*Treatment, Payment and Health Care Operations*”

– *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.

“*Use*” applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“*Disclosure*” applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) 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 Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child and Vulnerable Adult Abuse: If I become aware that you may be abusing, exploiting, or neglecting a child under age 18, a developmentally disabled person, or an elderly person, a report must be made to the appropriate authorities. (RCW 26.44)

Danger to Others: If you become a danger to others, I must protect the other person(s) and you by warning the other person(s) at risk and report the danger to the appropriate authorities. (RCW 71.05)

Health Oversight: If the Washington Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

HIV-related issues: If you tell me that you are suffering from HIV-related illness and do not have a physician providing for your care, I must report the identities of your IV drug using or sexual partner(s) to the local health care officer. (WAC 248-100-072)

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and 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. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this

decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – 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). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – 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.

Psychologist's Duties:

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.

If I revise my policies and procedures, I will notify you by mail with a revised version of this document.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact me at my business address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Office of Civil Rights, 200 Independence Ave. SW, Washington, D.C. 20201 (877-696-6775 toll free).

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 4-15-03. 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 by mail.

Assurances and Agreement

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I agree for my child _____ to have an evaluation by Dr. Jennifer R. Blair for the purpose of _____.

I understand that the evaluation may include an interview with me, my child, and with others who may know my child well, reviewing my child's medical and other records, and psychological, academic, and neuropsychological tests. I understand that Dr. Blair will explain her findings and recommendations to me following the evaluation. I understand that she will write a report summarizing the results of the evaluation, and that this report will be sent to those individuals I designate and will become a part of my child's records at this office.

I understand that the estimated total cost of the evaluation is _____. I understand that I will pay \$1000 of the evaluation via cash, check, or credit card at the time of the initial intake interview, and the remaining balance will be due at the time of the feedback session. Dr. Blair will provide me with a statement that I can submit to my insurance company after the feedback session.

I have read and understood the attached information about my rights and responsibilities. I have had a chance to have my questions answered.

Parent/Guardian Signature

Date

Relationship to Child

Child's Signature (required if age 13-17)

Date

Witness Signature

Date