

Steven Kovner, Ph.D.
Licensed Psychologist
4046 Wetherburn Way, Suite 7
Peachtree Corners, GA 30092
Phone: (770) 993-3002

Informed Consent for the Psychological Assessment of your Child

Welcome to my practice! Thank you for contacting me for the opportunity to help. I look forward to working with you and your child with the goals of understanding his or her abilities, including both the strengths and any areas of difficulty, and making recommendations that may include a range of interventions that can support the way your child learns and improve their experience in school and their confidence in everyday life. Although this document is long and sometimes complicated, please read it carefully in its entirety and ask any questions you have about the content. When you sign this document, it will represent an agreement between us.

CREDENTIALS:

I am a Licensed Psychologist in Georgia. I hold a doctoral degree from the University of South Carolina in School Psychology with an additional year in the Clinical Psychology program for supervision in adult Psychodynamic Psychotherapy, Marital, and Sex therapy. Therefore, I am qualified at the highest levels of service to see children, adolescents, adults, and couples.

To provide you with a more affordable service, I have discussed with you that a highly qualified Clinical Psychology Practicum student will provide all of your services under my supervision. Your therapist will both legally and professionally qualified to provide these services to you under my supervision.

PRACTICE STRUCTURE:

I am in independent practice and am not affiliated with any other individual or practice.

WHAT IS PSYCHOLOGICAL TESTING?

Psychological evaluation is a process that includes a combination of clinical interview, completion of written questionnaires, and use of a variety of standardized measures in two or more one-on-one appointments with you or your child or adolescent. Depending upon the individual concerns and questions to be answered by the evaluation, testing may include measures of:

- Cognitive Ability
- Academic Achievement and Learning Progress
- Attention and Executive Functioning
- Visual and Auditory Information Processing
- Problem Solving Strategies
- Motor and Visual Perceptual Abilities
- Memory
- Behavioral and Emotional Functioning

WHAT IS THE PROCESS?

The first appointment is an initial evaluation, which typically includes a discussion with the client. For children or adolescents, the parents are interviewed to learn more about the current concerns and difficulties, as well as to gather background history and information about school functioning and, to review the findings from written questionnaires completed in advance. Information from this meeting helps with the final selection of measures for the test battery. At this first meeting, you may be asked to provide additional records, such as report cards and prior testing reports and, for your written authorization to provide permission to communicate with other professionals involved in your child's care.

The testing sessions are usually scheduled in two or three sessions on separate days, typically in the morning, lasting 3-1/2 – 4 hours each. The specific measures chosen depend on the concerns to be addressed.

The family feedback meeting is scheduled 2 – 4 weeks after the final testing session -- and after all other supporting data and reports have been received -- to review the test results and recommendations. At that appointment, you will be provided with a comprehensive written report.

USE OF THE EVALUATION REPORT:

After the written report has been prepared and shared, the usual next step is to share the report with other involved professionals including but not limited to the school team, the pediatrician and other medical professionals. On many occasions, parents set up a meeting at the school to go over the recommendations and determine if additional supports can be put in place.

Please be aware that it is not in my control whether the school will agree to implement the recommendations. The recommendations will be practical, driven by the test data and relevant to the needs of your child in the context of the evaluation results.

While I stay up to date on the rules for provision of accommodations for standardized testing and the types of test instruments recommended for consideration for accommodations, I do not have any special power to obtain approval for accommodations for standardized testing such as the ACT, SAT or AP tests. I want you to know in advance that I will not change the presentation of the results, the diagnoses or the recommendations purely so that they meet criteria for special supports or accommodations; to do so would be unethical.

The standardized testing companies continue to be particularly conservative in granting accommodations to students who do not have a long standing history of receiving and using those very accommodations in their school setting. If the College Board or ACT denies the student accommodations, you may ask me to write a Letter of Appeal on the behalf of the student.

Typically, these letters must be completed in a short period of time and require a substantive review of the report and the denial. This type of letter takes additional time and will require a separate fee, which can be discussed if or when these circumstances occur for your child.

FEES AND PAYMENT:

A complete psychological evaluation involves the initial appointment, preceded by scoring and interpretation of written questionnaire measures sent in advance of the first appointment, followed by face-to-face testing measures with the examiner, usually over two to three appointments and taking seven to eight hours total. Testing also involves scoring and interpretation of the results and the preparation of an integrative written report. The writing of the report usually takes at least as many hours as and often even more hours to complete than the testing time itself.

The fee for the comprehensive psychological evaluation is generally \$ 2500.00. Other assessments are priced for more circumscribed assessments. The exact prices will be disclosed to you when the specific assessment battery is identified. Pricing will include a charge for the testing sessions, the family feedback meeting and the preparation of the comprehensive written report. The testing evaluation fee is due at the first testing session.

INSURANCE INFORMATION:

If I am an out-of-network provider, this means that I am not a member of a provider network for your managed care plan. Your insurance plan may or *may not* cover visits to an out-of-network provider. Some insurance companies reimburse at different amounts depending on whether you see a provider with whom they have a contract, called an “in-network” provider.

You are responsible for payment of all charges, submission of bills to your insurance company, obtaining information about your coverage and making certain that we are both aware of any authorization requirements for psychological testing. I will provide you with detailed receipts including all the necessary information should you choose to submit to your insurance company for reimbursement. Many insurance plans cover psychological services and many require the *member* to make a telephone call before an initial appointment. If you are interested in submitting for reimbursement, I recommend that you contact your insurance company to request information about out-of-network benefits for psychological consultation and testing prior to the first appointment.

If you call your insurance company, let them know that you are calling for “preauthorization for psychological testing.” They may ask you for CPT Codes. These are listed below.

90791 Initial Diagnostic Interview

96101 Psychological Testing

90847 Family Feedback Meeting

I suggest that you obtain any special forms and a fax number for paperwork that they tell you is required. If your insurance company authorizes the testing, they will use the date they *receive* the forms for the start date of the authorization. I am not in control of how quickly they will process this request or whether they will authorize testing at all. I will fill out forms if you provide them for me and will give you a copy of forms that I submit so that you can follow up with them directly.

CANCELLATION POLICY:

If you must cancel an appointment, please give a *minimum of 48 hours advance notice*. If this minimum is not provided, you will be charged a cancellation fee of \$ 50 for the initial appointment or family feedback meeting and a \$200 fee for the cancellation of a testing appointment. Given the large amount of reserved time made available to you for testing appointments, short notice cancellations for the testing sessions may result in the cancellation of subsequent appointments.

CONFIDENTIALITY:

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information to others with your (the patient or the parent for children and adolescent) written permission. There are a few exceptions that have rarely or never occurred in my practice but about which you should be informed:

- In proceedings involving custody or those in which your child’s emotional condition is an issue, a judge may determine that my testimony will be ordered. If you choose to include your child’s mental or emotional status as part of a court proceeding, doing so waives your privilege of confidentiality.

- If a patient or patient's parent or guardian files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I have reason to believe that a child has been subjected to abuse or neglect, the law requires that I file a report with the appropriate government agency.
- If you submit your bill to your insurance company for reimbursement, they require that I provide a clinical diagnosis and may also request clinical information. If your company requires forms to be completed to request authorization for psychological testing, these forms may include clinical information and diagnoses that are faxed to the company for review or discussed in a telephone call with a reviewer employed by the company.
- If you are divorced, both parents have equal ability to obtain information from mental health records and both parents *must* give permission for the provision of psychological services.

If a situation like one of those described above occurs, I will make every effort to fully discuss it with you before taking any action. Otherwise, I will not tell *anyone anything* about you or your child's evaluation or even that you are a patient, without your knowledge and written consent.

CONTACTING ME:

The best way to reach me is through the confidential voice mail answering system. Please be aware that I do not answer calls when I am in appointments, but I check voice mail often. I will make every effort to return your call within 24 – 48 hours, except for weekends and holidays, but cannot guarantee that this is always possible. If you are not able to reach me and feel that your child is having an acute mental health emergency and you cannot wait for a return call, please contact your child's medical provider or go to the nearest emergency room.

SPECIAL CIRCUMSTANCES:

I provide consultation, psychological evaluation, and psychotherapy services to assist with problem resolution and do not do specialized evaluations to be used in legal proceedings, such as for forensic issues or court proceedings for custody determination. If you anticipate that this is needed, I will refer you to professionals who have this area of specialization in their practice.

Although very unlikely, it is important that I share the following information in advance: In the event that I am required by subpoena or court order to testify in any matter related to the psychological evaluation services, you will be expected to pay for all of the professional time used, including preparation and transportation costs, even if I am called to testify by another party. If I am subpoenaed by another party in litigation with you and you do not wish the subpoena answered, it is your responsibility to contract with your lawyer to quash the subpoena or to sign a waiver of confidentiality.

Because of the substantial difficulty of managing such legal involvement while maintaining scheduled appointments in my practice at the same time, the fees are \$ 250 per hour for preparation and attendance at any legal proceeding.

Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

- You have been informed of and understand the type of services to be provided.
- You have been informed of the limits of confidentiality.
- You understand and agree to the payment and cancellation policies.
- You accept full responsibility for all fees incurred in completing the psychological evaluation as spelled out in the agreement.
- You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report.

Name of Patient: _____

Signature of Patient or Parent/Guardian

Date

Printed name serves as an electronic signature if you cannot sign

Relationship to Patient

Signature of Second Parent/Guardian

Date

Printed name serves as an electronic signature if you cannot sign

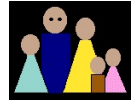
Relationship to Patient


CHILD CLIENT INFORMATION FORM

Today's Date:			
Presenting Problem:			
Client's Name:		School:	
Date of Birth:	Age:	Grade:	
Custodial Parent's Name(s):		Non-Custodial Parent's Name:	
Home Address:		Home Address:	
City/State/Zip:		City/State/Zip:	
Custodial Parent's Cell Phone:		Non-Custodial Parent's Cell Phone:	
Custodial Parent's EMail:		Non-Custodial Parent's EMail:	
Custodial Parent's Occupation:		Non-Custodial Parent's Occupation:	
Siblings': Names/Ages:		Step Mother:	
		Step Father:	
Pediatrician's Name:		Phone Number:	
INSURED'S INFORMATION IF USING INSURANCE			
Primary Insurance Company:		Secondary Insurance Company:	
Insured's Name:		Insured's Name:	
Insured's Employer:		Insured's Employer:	
Insured's Date of Birth:		Insured's Date of Birth:	
Address:		Address:	
State/Zip Code:		State/Zip Code:	
Ins. Co. Tel. #:		Ins. Co. Tel. #:	
Employer:		Employer:	
Policy Number:		Policy Number:	
Group Number:		Group Number:	
Effective Date:		Effective Date:	
Deductible:		Deductible:	
Amount Met:		Amount Met:	
# of Sess. Per Cal. Yr.:		# of Sess. Per Cal. Yr.:	
Co-Pay:		Co-Pay:	
Precert? Auth. #:		Initial Diagnostic Impression:	

CREDIT CARD AND AUTHORIZATION FORM

<i>Credit Card Holder:</i>		<p style="text-align: center;"><i>The services rendered are checked below.</i></p> <div style="display: flex; justify-content: space-between;"> <i>() Diagnostic Interview</i> <i>() Psychotherapy 50-60 Min.</i> </div> <div style="display: flex; justify-content: space-between;"> <i>() Psychological Evaluation</i> <i>() Court Testimony</i> </div> <div style="display: flex; justify-content: space-between;"> <i>() Two-Day Couples Retreat</i> <i>() Written Correspondence</i> </div> <div style="display: flex; justify-content: space-between;"> <i>() Test Results Feedback</i> <i>() School Board, IEP or Tribunal Hearing</i> </div> <div style="display: flex; justify-content: space-between;"> <i>() Phone Consultations greater than 10 minutes</i> </div>
<i>Credit Card Number:</i>		
<i>Zip Code:</i>		
<i>Expirations Date:</i>	<i>Security Code:</i>	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p style="text-align: center;"><i>Authorizing Signature</i></p> <p style="text-align: center;"><i>Your typed name will represent your signature if you cannot sign.</i></p> </div> <div style="width: 45%;"> <p style="text-align: center;"><i>Date</i></p> </div> </div>		



OFFICE POLICIES AND PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information at or before the end of the first meeting. Although these documents are long and sometimes complex, it is very important that you read them carefully. I can discuss any questions you have about the procedures during the first meeting. 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.

PSYCHOLOGICAL SERVICES

I specialize in the assessment, diagnosis and treatment of learning, relationship, psychological, and some neuropsychological disorders. By signing this agreement, you are giving consent for yourself or your child/adolescent to undergo psychological evaluation and/or treatment. As a licensed psychologist, I will be performing this evaluation and/or treatment.

Psychological Testing

A psychological evaluation is a comprehensive assessment of cognitive, educational, and social/emotional functioning. Over a period of 4 to 8 hours, standard testing procedures assess various abilities that relate to cognition, learning, memory, problem solving and critical thinking. The evaluation also measures psychological dimensions relating to social and emotional functioning. The evaluation may also be used to procure public school or college classroom/teaching accommodations for you or your child in order to obtain more effective learning experiences. Also, psychological testing may be used to provide medical clearance, fitness for duty to return to work, or parental competence in a court of law. If you have further questions about the purpose and potential benefits of a psychological evaluation, I will be happy to provide additional information.

Psychotherapy

Psychotherapy, or mental health counseling, is a complex array of many activities that serve to build a trusting relationship between the client and their therapist. This array of activities may consist of play, dance or movement, physical exercise, education, learning, application and practice of that learning, assimilation of learning into behavior and integration of what is learned and practiced into ethical, morally mature, socially responsible and healthy personality functioning. The transformation that occurs through this complex array of activities with the therapist involves easing of personal defense mechanisms that permit insight into one's own emotional life and habitual ways of behaving socially.

Self-control and improved social and moral functioning comes through the development of self-awareness, rational thought, appropriate expression of emotions, planning, anticipation of consequences, mental flexibility, self-acceptance, genuine regard for others' feelings, beliefs, and opinions, and capitalizing on one's existing strengths and resources. By forming a therapeutic alliance with Dr. Kovner the client works to improve their chances of success in achieving the goals of emotional stability, personal and interpersonal growth, occupational and educational satisfaction and social responsibility. Furthermore, research has shown that improvement in mental health can have a beneficial affect on physical health.

Children and Adolescent Clinical Records

With regards to your child or adolescent, the review of the clinical record would violate the client's confidentiality. Without privacy, most children and adolescents would not talk or disclose matters of true concern and therapy would not be effective. There may be general discussion with you about the goals, progress and effectiveness of therapy at Dr. Kovner's discretion. However, if during the course of treatment, if I were to become concerned that your child's life or safety was endangered your child's confidentiality privileges would be waived. Therefore, before I would agree to treat your child (or adolescent) I request that you consent to waive your right to have a copy of or review the details of the clinical record by signing in the space below.

I, _____, the parent or legal guardian of _____
(Print Parents' or Legal Guardian's Names)

whose date of birth is _____, waive my right to read, review or own a copy of the clinical record.

Please note that in some cases our files may include information from other treatment providers that clients have given me written permission to obtain. If you have given me permission to obtain such records, I cannot provide them to you if you ask to review your files. Instead, I would ask for you to contact the provider who created the records and obtain copies directly from her or him.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. I am happy to discuss any of these rights with you.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about you or your child's treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Georgia law. However, in the following situations, no authorization is required: Disclosures required by health insurers or to collect overdue fees; if you are involved in a court proceeding and a judge waives your privilege to confidentiality. Generally, I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. In the case of suspected child abuse, the privilege is waived because all psychologists are mandated court reporters of child abuse.

Additionally, I would not need authorization to disclose your records under the following circumstances:

1. If a you file a complaint or lawsuit against me, I may disclose relevant information regarding you and your treatment in order to defend myself.
2. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
3. You should be aware that I practice with other mental health professionals and that I occasionally employ administrative staff. In some cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations in which we are legally obligated to take actions where your confidentiality privileges are waived. These situations include instances where we believe it is necessary to attempt to protect others from harm. Under such circumstances, I may have to reveal some information about a patient's treatment. These situations are unusual in our practice, and include:

4. If I know or have reasonable cause to suspect that a child under 18 has been or is likely to be abused or neglected or that a disabled person has been abused, neglected or exploited, the law requires that I file a report with the appropriate government agency, usually the Georgia Department of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
5. If I determine that the patient poses a direct threat of imminent harm to the health or safety of any individual, including himself/herself, I may be required to disclose information in order to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can assist in providing protection.
6. If you have filed a worker's compensation claim and I are being compensated for your treatment by your employer or its insurance company as a result of that claim, I must provide, upon appropriate request, legally required reports and other information related to your condition.

INSURANCE & CONFIDENTIALITY

You should be aware that most insurance companies require you to authorize your treating psychologist to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment

plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information data bank. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit our disclosure to what is necessary.

Please indicate below your intention to use health insurance.

I have decided:

) not to utilize my health insurance to cover the cost of this evaluation.

to use my health insurance to cover the cost of these services. My signature on this agreement verifies that I understand that a pre-authorization from my insurance company is not a guarantee that your insurance company will pay for this evaluation. If your insurance company chooses not to pay, or to pay only partially for this service, you have agreed to pay the full amount

My usual and customary fee is \$200.00 per hour. I charge this amount for other professional services you may need. Other services include:

- Psychological Testing
- Report Writing
- Telephone consultations lasting longer than 10 minutes
- Consultations with other professionals
- Preparing records or treatment summaries for court

If you become involved in legal proceedings through the court system or hire me to support your child in an IEP meeting, Board Meeting, or Tribunal Hearing through the school system, you will be charged \$200.00 per hour for travel, wait time, preparation and attendance. I require a \$1,600.00 retainer before work is begun.

If you plan to use your health care insurance, you are expected to contact them and be informed of your Mental Health benefits. We cannot be responsible for interpreting your insurance benefits. Unless your insurance company has contracted directly with the Kovner Center, this office cannot call, contact or negotiate for you with your insurance company. However, we will print out statements for you to submit for reimbursement. Any special arrangements must be discussed in advanced with the office manager. Missed appointments are generally not insurance reimbursable.

CANCELLATION POLICY AND RESCHEDULING APPOINTMENTS

In order to accommodate you we offer flexible appointment hours, including after-school and evening hours. When you schedule an appointment, that time is yours and you pay for that time whether you use it and attend your appointment or you fail to show up or fail to cancel your appointment at least two days prior. We charge a \$50.00 fee for not canceling your appointment 2 days in advance. We refer to this as the ***Cancellation Fee***. The fee may be waived at Dr. Kovner's discretion when you were unable to attend due to circumstances beyond your control.

Individuals who miss two consecutive appointments without advanced notification will be taken off the calendar. There may be situations when I agree that you were unable to attend due to circumstances beyond your control. Under these circumstances, the fee will be waived at Dr. Kovner's discretion.

RETURNED CHECK FEES

There will be a \$35.00 charge for each returned check to cover all of the expenses involved in paying bank fees and other resulting insufficient funds charges.

LATE FEES AND NON-PAYMENT ACTIONS

After 30 days 1% of a 12% annual interest charge is added to the standing balance on your account. Interest will accrue monthly. After 90 days of not making payments, a collection action will be taken, including a report to all three credit companies. A Small Claims suit will be filed. Afterwards, Garnishment of your banking assets or those held by your employer will be pursued in Small Claims Court.

EATING OR SMOKING

No Eating or Smoking is permitted in the Building. If you smoke outside, please throw your used cigarette into the plastic receptacle out front. Children are to wait quietly in the waiting room. Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not leave children unsupervised in or outside of the office.

THE WAITING AREA

Clients are to wait quietly in the waiting room. Please be courteous and turn your cell phones to vibrate. Please use ear buds to listen to music and voices down to a whisper if you talk on your cell phone. We use the radio to provide the Office Manager privacy.

OFFICE MANAGER

Please respect the Office Manager's time and privacy. Make payments at the window. Do not share any clinical information with the Office Manager as she is not responsible for conveying clinical information to Dr. Kovner.

The Kovner Center is not responsible for sending out appointment reminders. You can set up reminders on your electronic calendar. Please ask for your appointments to be recorded on a business/appointment card for your records.

Any copies of records, claims forms, or other documents will be provided at the convenience of the Office Manager at a cost of \$.20 per page plus postage and handling charges of \$10.00 will be applied if applicable.

ACKNOWLEDGMENT OF REVIEW OF OUR OFFICE, FINANCIAL AND CANCELLATION POLICIES & AGREEMENTS, AND PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with, understand and accept the policies in the “HIPAA Notice of Privacy Practices” as well as Dr. Kovner’s “Office Policies, Cancellation Requirements” and Financial Obligations. Therefore, I have been advised of how health information about me may be used and disclosed by Dr. Kovner, how I may obtain access to and control this information and my responsibilities to pay all fees not covered by insurance and the costs associated with late fees and collection services.

 X

Signature of Patient or Personal Representative (Type Your Name if You Cannot Sign)	DATE
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1. Please list who you want to have access to your pertinent medical information? (i.e.: family member, spouse, significant other):

<i>Name</i>	<i>Relationship to Client</i>	<i>Phone Number</i>
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<i>Name</i>	<i>Relationship to Client</i>	<i>Phone Number</i>
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<i>Name</i>	<i>Relationship to Client</i>	<i>Phone Number</i>
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2. May we leave a message on your answering machine? YES NO

3. Preferred method of contacting you:

Home # _____ *Cell #* _____ *Work #* _____

THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGMENT IS NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgment, but the acknowledgment was not obtained for the following reason(s):

The individual refuses to sign and/or did not return his or her receipt of the Acknowledgment.

Other:

Date:

PARENT'S QUESTIONNAIRE

Today's Date: _____

Child's Name:		Date of Birth:		Age:	
Referred By:					
Presenting problem:					
Family Relationships					
Biological Mother's Name:		Biological Father's Name:			
Education:		Education:			
Occupation:		Occupation:			
Stepfather:		Stepmother:			
Guardian:		Siblings:			
How does child get along with siblings?					
CHILD'S BIRTH AND EARLY DEVELOPMENT					
Was pregnancy planned?					
Premature? If yes, how weeks?					
Adopted?					
Birth Weight					
How was mother's health during pregnancy?					
Any problems at birth?					
Any feeding difficulties?					
Any sleep difficulties?					
Approximate age when child: Sat alone					
Walked alone					
Correctly used one-word speech					
3-word sentences					
Any hearing difficulties?					
Any trouble with eyesight ?					

Anything unusual about speech development?			
Is child over or under active?			
Is child excessively aggressive?			
How does child react to new situations and changes in routine?			
Please check any of the problems below that your child has:			
Fingernail biting	Thumb sucking	Body rocking	Sleep walking
Fire setting	Temper tantrums	Stealing	Truancy)
Accident proneness	Concerns about eating	Concerns about sleep habits	
Self-injury	Unusual perceptions	Night terrors of nightmares	

EDUCATIONAL HISTORY List in chronological order all

schools your child has attended.							
<u>Name of School</u>	<u>Dates Attended</u>				<u>Grade Level</u>	<u>GPA</u>	<u>Conduct</u>
	From		To				
	From		To				
	From		To				
	From		To				
	From		To				
	From		To				

Name of current teachers _____

Child's favorite subjects _____

Child's least favorite subjects _____

Has your child ever repeated a grade? _____ If so, which? _____

Has your child ever skipped a grade? _____ If so, which? _____

Has your child ever received tutoring? _____

Has your child ever been in a Special Education Program? _____ If so, in which subject(s)? _____
 If so, during which years? _____

What type of Program? (Gifted, LD, BD/EH, MR?) _____

Child's attitude toward school _____

How well does your child get along with other children? _____

Please describe your child's strengths _____

Describe your child's weaknesses _____

Child's extracurricular activities including sports, hobbies, clubs, lessons, etc.

Baseball _____	Karate _____	Dance _____
Football _____	Piano _____	(type) _____
Basketball _____	Cheerleading _____	Music _____
Soccer _____	Scouts _____	Other: _____

List any additional special abilities, skills, strengths your child has. _____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings? _____

Has your child been hospitalized for a psychiatric condition? If yes, when and where? _____

_____ Is your child taking medication? If yes, what medications are they, what dose, and for what condition?

For what Condition Medication is Prescribed for?	Date Prescribed?	Name of Medication?	Dose?

Are there any family members on either side of the family who have ever been treated for mental or emotional problems? If yes, specify. _____

Parents' Self-Descriptions

How would you rate your overall level of happiness on a scale from 1 (Happy) to 10 (Unhappy).

Mother _____ Father _____

On a scale from 1 (Low) to 10 (High), how would you rate your stress in the following areas ?

Mother's Ratings Father's Ratings

Job		
Home Life		
Parenting		
Friends/Social Life		
Day to day hassles		
Your marriage		
Finances		
Intimacy		
Communication		
Time Together		
Overall Stress		

DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies with them on a scale from 1 (Unlikely) to 5 (Likely). Also, please indicate how effective each of the disciplinary strategies is for your child by rating them from 1 (Ineffective) to 5 (Effective). Either circle the number or write the number in the field to the right of the score range.

	Unlikely		Likely		Ineffective		Effective
1. Let situation go.....	1	2	3	4	5	1	2 3 4 5
2. Use token system.....	1	2	3	4	5	1	2 3 4 5
3. Take away a privilege (e.g., T.V.).....	1	2	3	4	5	1	2 3 4 5
4. Use charts & stickers.....	1	2	3	4	5	1	2 3 4 5
5. Earn privileges.....	1	2	3	4	5	1	2 3 4 5
6. Earn time with friends.....	1	2	3	4	5	1	2 3 4 5
7. Take away something material (e.g., no dessert).....	1	2	3	4	5	1	2 3 4 5
8. Earn special time with parents.....	1	2	3	4	5	1	2 3 4 5
9. Send to room.....	1	2	3	4	5	1	2 3 4 5
10. Give verbal praise.....	1	2	3	4	5	1	2 3 4 5
11. Physical punishment.....	1	2	3	4	5	1	2 3 4 5
12. Reason with child.....	1	2	3	4	5	1	2 3 4 5
13. Earns material or food reward.....	1	2	3	4	5	1	2 3 4 5
14. Teach desired behavior by discussion.....	1	2	3	4	5	1	2 3 4 5
15. Ground child.....	1	2	3	4	5	1	2 3 4 5
16. Teach appropriate behavior by modeling.....	1	2	3	4	5	1	2 3 4 5
17. Yell at child.....	1	2	3	4	5	1	2 3 4 5
18. Teach desired behavior by role-playing.....	1	2	3	4	5	1	2 3 4 5
19. Earn participation in social activities.....	1	2	3	4	5	1	2 3 4 5
20. Send to time-out.....	1	2	3	4	5	1	2 3 4 5
21. Reward positive behavior.....	1	2	3	4	5	1	2 3 4 5
22. List anything else you may do: _____	1	2	3	4	5	1	2 3 4 5
23. _____	1	2	3	4	5	1	2 3 4 5
24. _____	1	2	3	4	5	1	2 3 4 5
25. _____	1	2	3	4	5	1	2 3 4 5
26. _____	1	2	3	4	5	1	2 3 4 5



*Steven Kovner, Ph.D.,
Licensed Psychologist
and Director*

TELEPSYCHOLOGY INFORMED CONSENT

Welcome to my practice. I am Steven Kovner, Ph.D., a licensed psychologist in Georgia. I have a doctoral degree in School Psychology and additional Clinical Psychology coursework and supervision in adult psychotherapy, marital and sex therapy. I see adults, couples, adolescents and children for assessment and treatment of a variety of personality, emotional, behavioral, and relationship problems.

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. If a need for direct, face to face services arises, it is my responsibility to contact this office for a face to face appointment. I understand that an opening may not be immediately available.
3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.
4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
 - a. I understand that the Kovner Center does not provide 24/7 emergency coverage and in the event of an emergency I will contact the emergency operator and call 911, call the National Suicide Prevention Lifeline at 800-273-8255, or go to my local hospital emergency room.
 - b. Should service be disrupted you will not be billed for the service and an attempt will be made to reconnect you with your therapist by calling you on your cell phone to complete the session.
 - c. For other communication, the Kovner Center will only communicate administrative matters with you, such as booking appointments or sending you educational/therapeutic materials that contain none of your private health or mental health information. Since your Email may not be safe and could be subject to hacking or theft, we advise you not to send clinical information over through your email unless you know that it is encrypted and compatible with the HIPAA standards of privacy. If you do send information to me using your email, you assume all responsibility for any breach or theft of your information.

6. My psychologist/therapist will respond to communications and routine messages within 24 hours.
7. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
8. My communications exchanged with my psychologist/therapist will be stored in the office located at 4046 Wetherburn Way, Suite 7, Peachtree Corners, Georgia 30092 and kept for 10 years.
9. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

Signature of Client or Legal Guardian (Printed
name will represent client's electronic signature)

Date

<i>Client's Name:</i>		<i>Age:</i>		<i>Observer:</i>	
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Stereotyped/Repetitive Speech/Motor Movements Use of Objects and Sensory Sensitivities:

Currently Toe Walks or Toe Walked from ages 1 , 2 , 3 , 4 5 , 6 to 1 , 2 , 3 , 4 5 , 6
 Runs in circles by history.
 Bangs on the wall by history.
 Over focused on _____ by history.
 Hand flapping by history.
 Tends to spin objects by history.
 Lines things up and rigidly organizes objects by history.
 Sensitive to certain textures: _____ by history.
 Sensitive to noises by history.
 Sensitive to and avoids crowded places by history.

Motor skills:

Early motor milestones were met within normal limits.
 walks runs, walks up/down stairs, hops on one foot, and pedals a tricycle/similar type of item straight and around corners. Can use a scooter to ride around.
 Has difficulty has no difficulty catching items (even a beach ball from about 6 feet away).
 Has difficulty has no difficulty holding a writing implement appropriately with fingers and prefers to hold them in an awkward manner.
 Can Cannot draw a circle, square, and triangle.
 Is or Is not interested drawing with colors.
 Cuts Cannot cut a straight line cuts or Cannot cut out simple shapes with scissors.
 Does or Does not tie knots.
 Is or Is not able to open up lunch containers to eat her lunch.
 Scribbles or Cannot scribble with drawing/writing items.
 Writes or Cannot write the letters of the alphabet
 Writes or Cannot write numbers 1 through 10.
 Written letters and numbers are or are not often drawn sloppy.
 Traces or Cannot trace sight words.
 Can or Cannot write first name from memory.

Toileting:

Knows or does not know where the bathroom is.
 Goes or Does not go to the bathroom when told.
 Does well or Doe not do well on a toileting schedule.
 Tends to hold bowl movements and avoid having a bowel movement on the toilet.
 Asks or Does not ask to go to the bathroom
 Has or Has no greater difficulty with using the toilet for bowel movements.

Other Hygiene/Self-Care:

Feeds or Does not self with utensils.
 Removes clothes or Does not remove clothes independently, including taking off pullover garments, shoes, socks, and pants. Dresses self independently or cannot dress self independently with clothing that opens in the front (so long as no zipping/buttoning is required).

Puts or cannot put on pullover-the-head clothing.
 Puts or Cannot put on shoes (sometimes may mix up the foot).
 Does or Does not tie laces. Can or cannot use Velcro).
 Never or Sometimes requires support to ensure that the clothes are the right side out and not backwards.
 Does or does not attach zippers
 Does or does not button independently.
 Never or requires support for bathing.
 Independently brushes teeth
 Independently brushes hair.
 For showering, Follows parent's step by step instructions.
 Help parent switch clothes from the washer to the dryer.
 Likes or Does not like to help sweep the floor.
 Likes to help stir foods.
 Puts or does not put used plates/cups in the sink.
 Puts or does not put items away.
 Understands or does not understand that a clock is used to tell time.
 Does or Does not tell time on own yet.
 Understands or does not understand that a credit card/money is used to buy items
 Knows or Does not know the names of most/all coins/bills.
 Does or does not know the value of coins/bills.
 Stays or does not stay in the car seat when riding in the car.
 Requires or does not require support to cross a street.

Communication/language skills:

Does or does not have delays in the development and use of language and communication.
 Spoke 4 to 5 words at 1 years old but soon after stopped using those words or any other words.
 Started to speak at 18 to 20 months old.
 Currently uses 2 to 3 word phrases or sentences independently or with a prompt.
 Without a prompt most often uses single words
 Uses 2 to 3 word phrases without prompting/encouragement.
 When highly motivated for an item and is not able to access the item independently will often spontaneously make requests using 2-3 words.
 Does or does not have conversations with others.
 Does or does not say first name when asked.
 Does or does not use gestures to communicate.
 Makes or does not make eye contact with others.
 Does or does not use her eye gaze when communicating with others.
 Does or does not currently understand and complete most simple commands in English.
 Sometimes says "no" or may ignore a command.
 Does or does not complete simple two step demands.
 Does or does not have difficulty completing multiple step demands even if motivated.
 Can or cannot follow if-then type instructions, even when motivated.
 Reads 4 to 5 word sentences on her own.
 Counts to 100 on independently.

Friendships, Peer Interactions, and Play:

Does or does not interact and play with peers for physical activities.
 For example, sometimes rides scooter/tricycles with others.

If peers are playing tag, _____ will runs with them but _____ not participate in the tag game.
When peers come to patient's house, patient does _____ or _____ does not run around with them in the backyard.

Enjoys or _____ does not enjoy the park playground equipment.

Typically plays _____ alone but _____ sometimes runs on the outside or around peers without mingling and fully joining in.

If others approach _____ may play a "catch me" type of game or _____ ignore them and walk away.

Enjoys kissing and cuddling with sibling(s).

Enjoys running around with sibling(s).

When her sibling tries to take a toy from patient, patient _____ "fights with sibling."

Sometimes shares when told to share.d

Sometimes throws the item when told to share.

Enjoys being on the iPad/electronics

Enjoys being outside

Enjoys going outside for a walk,

Enjoys riding a bicycle/scooter,

Enjoys being in the lawn/garden when parent is working in it, _____ water the plants,

Feeding the pets.

Enjoys musical toys

Enjoys puzzles.

Compelled to arrange items

Engages or _____ does not engage in independent pretend play.

Other Social Emotional Behavioral:

Recognizes or _____ does not emotions in others.

Imitates or _____ does not imitate what others do.

Is or _____ is not noncompliant.

Whines or _____ does not whin.

Throws or _____ does not throw objects.

Grabs or _____ does not grab objects from others.

Difficulty or _____ no difficulty sustaining attention.

Has or _____ does not have difficulty paying attention in parking lots.

Has or _____ does not have difficulty shifting attention and transitioning away from a more preferred activity.

Additional Observations and Comments:

CHILDREN'S SYMPTOM CHECKLIST®

by Steven Kovner, Ph.D.

(To be filled out by the parents)

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Person Filling Out this Form: _____
Relation to Child: _____

DIRECTIONS: (To be filled out by the child.) This inventory is designed to get a picture of the presenting symptoms you are experiencing. Read each item carefully and don't spend too much time on any one item. If you are displaying the symptoms at all, place a check before that item.

_____ Fails to give close attention to details or makes careless mistakes

_____ Has difficulty sustaining attention and concentrating

_____ Does not appear to listen

_____ Struggles to follow through on instructions

_____ Has difficulty with organization

_____ Avoids or dislikes tasks requiring sustained mental effort

_____ Is easily distracted

_____ Is forgetful in daily activities

_____ Fidgets with hands or feet or squirms in chair

_____ Has difficulty remaining seated

_____ Runs around or climbs excessively

_____ Has difficulty engaging in activities quietly

_____ Acts as if driven by a motor

_____ Talks excessively

_____ Blurts out answers before questions have been completed

_____ Has difficulty waiting or taking turns

_____ Interrupts or intrudes upon others

ADD

_____ Negativity

_____ Defiance

_____ Disobedience

_____ Hostility directed toward authority figures

_____ Temper tantrums

_____ Argumentativeness with adults

_____ Refusal to comply with adult requests or rules

- ___ *Deliberate annoyance of other people*
- ___ *Blaming others for mistakes or misbehavior*
- ___ *Acting touchy and easily annoyed*
- ___ *Anger and resentment*
- ___ *Spiteful or vindictive behavior*
- ___ *Aggressiveness toward peers and/or siblings*
- ___ *Difficulty maintaining friendships*
- ___ *Academic problems*
- ___ *Aggressive behavior that harms or threatens other people or animals*
- ___ *Destructive behavior that damages or destroys property*
- ___ *Lying*
- ___ *Truancy or other serious violations of rules*
- ___ *Early tobacco, alcohol, and substance use*
- ___ *Precocious sexual activity*
- ___ *Exhibits physical acts of cruelty to people or animals*
- ___ *Frequently involved in fights, bullying or intimidation*
- ___ *Will use a weapon in fights*
- ___ *Steals*
- ___ *Tends to run away from home*
- ___ *Ignores set curfew times*

OD/CD

- | | |
|--|---|
| ___ <i>Headaches</i> | |
| ___ <i>Vague physical problems that result in missing school with visits to the doctor</i> | |
| ___ <i>Abdominal pain</i> | |
| ___ <i>Nausea</i> | |
| ___ <i>Vomiting</i> | ___ <i>Unusual flare-ups or outbreaks of temper</i> |
| ___ <i>Red eyes</i> | ___ <i>Withdrawal from responsibility</i> |
| ___ <i>Swelling</i> | ___ <i>General changes in overall attitude</i> |
| ___ <i>Blackouts, not remembering periods of time</i> | |
| ___ <i>Numbness in the arms or legs</i> | |
| ___ <i>Mood swings</i> | |
| ___ <i>Missing social events due to illness</i> | |
| ___ <i>Losing interest in social activities</i> | |
| ___ <i>Back pain</i> | |

SOM

- ___ *Sudden personality changes that include abrupt changes in school attendance, quality of school work, work output, or grades*

- ___ *Feelings of sadness that last for long periods of time.*
- ___ *Loss of interest in what were once favorite hobbies and pursuits*
- ___ *Changes in friends and reluctance to have friends visit or talk about them*
- ___ *Loss of appetite*
- ___ *Not sleeping well*
- ___ *Deterioration of physical appearance and grooming*
- ___ *Wearing of sunglasses at inappropriate times*
- ___ *Low self-esteem*
- ___ *Life has lost meaning*
- ___ *Thoughts of death or dying*

DEP

- ___ *Shyness*
- ___ *Compulsions*
- ___ *Phobias*
- ___ *Stress*
- ___ *Fears rejection*
- ___ *Fear of heights*
- ___ *Cannot speak in front of a group*
- ___ *Fear of germs*
- ___ *Constant re-checking, re-writing, e.g., homework, if doors are locked, book bag contents, etc.*
- ___ *Fear of needles*
- ___ *Obsessions*
- ___ *Thumb sucking*
- ___ *Hair pulling, nail biting, skin picking*
- ___ *Blushing*
- ___ *Excessive worries*
- ___ *Excessive computer games, use of the internet, phone screen time, etc.*
- ___ *Social anxiety*
- ___ *Lack of confidence*
- ___ *Fatigue*
- ___ *Fear of flying*
- ___ *Panic attacks*
- ___ *Morbid thoughts*
- ___ *An unrealistic and lasting worry that something bad will happen to the parent or caregiver*
- ___ *An unrealistic and lasting worry that something bad will happen to the child if he or she leaves the caregiver.*
- ___ *Refusal to go to school in order to stay with the caregiver.*
- ___ *Refusal to go to sleep without the caregiver being nearby or to sleep away from home.*

- _____ *Fear of being alone.*
- _____ *Nightmares about being separated.*
- _____ *Bed wetting*
- _____ *Complaints of physical symptoms, such as headaches and stomachaches, on school days. SEP*
- _____ *Seeing or hearing things that don't exist (hallucinations), especially voices*
- _____ *Having beliefs not based on reality (delusions)*
- _____ *Lack of emotion Emotions inappropriate for the situation*
- _____ *Social withdrawal Poor school performance*
- _____ *Decreased ability to practice self-care*
- _____ *Strange eating rituals Incoherent speech*
- _____ *Illogical thinking Agitation*

PSY

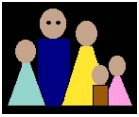
- _____ *Refusing to eat and denying hunger*
- _____ *An intense fear of gaining weight*
- _____ *Negative or distorted self-image*
- _____ *Preoccupation with food*
- _____ *Thin appearance*
- _____ *Dizziness or fainting*
- _____ *Soft, downy hair present on the body*
- _____ *Constipation*
- _____ *Abdominal pain*
- _____ *Dry skin*
- _____ *Frequently being cold*
- _____ *Irregular heart rhythms*
- _____ *Low blood pressure*
- _____ *Dehydration*

ED

ADVERSE CHILDHOOD EXPERIENCES

Instructions: Click on the Check Box at the end of each item that applies to your child.

- Did a parent or other adult in the household often or very often swear, insult or put your child down?
- Did a parents often or very often push, grab, slap or throw something at your child?
- Did a parents often or very often hit your child so hard that they left marks or injured your child?
- Did an adult or person at least 5 years older ever touch your child in a sexual way?
- Did an adult or perosn at least 5 years older ever attempt oral, anal, or vaginal intercourse with your chid?
- Did your child's mother or father sometimes, often , or very often push, grab, slap, or throw something at your child?
- Did you witness your child's father or mother sometimes, often , or very often, kick, bite, hit with a fist, or hit your child with something hard?



Steven Kovner, Ph.D.,
Georgia Licensed
Psychologist

INFORMED CONSENT FORM-CHILD OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

CREDENTIALS

I am a Licensed Psychologist in Georgia. I hold a doctoral degree from the University of South Carolina in School Psychology with an additional year in the Clinical Psychology program for supervision in adult Psychodynamic Psychotherapy, Marital, and Sex therapy.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one [60-minute] session per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide a 48 hour advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is \$175.00. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. [I charge \$250.00 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of \$.15 per page for records requests.]

BILLING AND PAYMENTS

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. Payment schedules for other professional services will be agreed to when such services are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

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. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. 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 the 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.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information

confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by the insurance contract].

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between [10 AM and 5 PM], I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by an answering machine, voice mail, or, if available, by the Office Manager, Janelle, who knows where to reach me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

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 therapy 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.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused or has been abused, I am required to make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I do not reveal the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney. [If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.]

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PATIENT SIGNATURE _____ DATE _____

Printing your name above will be
considered your electronic signature

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Example: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

Example: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also,

when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of [Georgia] may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of \$250.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date _____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

Parent/Guardian Signature _____
Your printed name is your electronic signature

Date _____

Parent/Guardian Signature _____
Your printed name is your electronic signature

Date _____

The Kovner Center For Behavioral Health & Psychological Testing

4046 Wetherburn Way, Suite 7
Peachtree Corners, Georgia 30092

Health Insurance Portability and
Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY:

The Kovner Center is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that The Kovner Center maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, The Kovner Center is required to ensure that your PHI is kept private. This Notice explains when, why, and how The Kovner Center would use and/or disclose your PHI. Use of PHI means when The Kovner Center shares, applies, utilizes, examines, or analyzes information

within its practice; PHI is disclosed when The Kovner Center releases, transfers, gives, or otherwise reveals it to a third party outside of the The Kovner Center. With some exceptions, The Kovner Center may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, The Kovner Center is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by The Kovner Center. Please note that The Kovner Center reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that The Kovner Center has created or maintained in the past and for any of your records that The Kovner Center may create or maintain in the future. The Kovner Center will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of The Kovner Center's Notice of Privacy Practices.

IV. HOW The Kovner Center MAY USE AND DISCLOSE YOUR PHI: The Kovner Center will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: The Kovner Center may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care.

Example: If you are also seeing a psychiatrist for medication management, The Kovner Center may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, The Kovner Center will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: The Kovner Center may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3. To Obtain Payment for Treatment: The Kovner Center may use and disclose your PHI to bill and collect payment for the treatment and services The Kovner Center provided to you. Example: The Kovner Center might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. The Kovner Center could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for The Kovner Center's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, The Kovner Center will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to The Kovner Center by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, The Kovner Center will have a written contract that requires the

employee or business associate to maintain the same high standards of safeguarding your privacy that is required of The Kovner Center.

Note: This state and Federal law provides additional protection for certain types of health information, including alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how The Kovner Center may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – The Kovner Center may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, The Kovner Center may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: The Kovner Center may make a disclosure to the appropriate officials when a law requires The Kovner Center to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** The Kovner Center may disclose information about you to respond to a court or administrative order or a search warrant. The Kovner Center may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. The Kovner Center will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the

information requested.

3. **Public Health Risks:** The Kovner Center may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.

4. Food and Drug Administration (FDA):

The Kovner Center may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

5. **Serious Threat to Health or Safety:** The Kovner Center may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if The Kovner Center determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, The Kovner Center may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

6. **Minors:** If you are a minor (under 18 years of age), The Kovner Center may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.

7. **Abuse and Neglect:** The Kovner Center may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If The Kovner Center has a reasonable suspicion of child abuse or neglect, The Kovner Center will report this to the Georgia Department of Child and Family Services.

8. **Coroners, Medical Examiners, and Funeral Directors:** The Kovner Center may release PHI

about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. The Kovner Center may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.

9. **Communications with Family, Friends, or Others:** The Kovner Center may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, The Kovner Center may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

10. **Military and Veterans:** If you are a member of the armed forces, The Kovner Center may release PHI about you as required by military command authorities. The Kovner Center may also release PHI about foreign military personnel to the appropriate military authority.

11. **National Security, Protective Services for the President, and Intelligence Activities:** The Kovner Center may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.

12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, The Kovner Center may

disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

13. For Research Purposes: In certain limited circumstances, The Kovner Center may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.

14. For Workers' Compensation Purposes: The Kovner Center may provide PHI in order to comply with Workers' Compensation or similar programs established by law.

15. Appointment Reminders: The Kovner Center is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.

16. Health Oversight Activities: The Kovner Center may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess The Kovner Center's compliance with HIPAA regulations.

17. If Disclosure is Otherwise Specifically Required by Law.

18. In the Following Cases, The Kovner Center Will Never Share Your Information Unless You Give us Written Permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, The Kovner Center will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying The Kovner Center in writing of your decision. You understand that The Kovner Center is unable to take back any disclosures it has already made with your permission, The Kovner Center will continue to comply with laws that require certain disclosures, and The Kovner Center is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in The Kovner Center's possession, or to get copies of it; however, you must request it in writing. If The Kovner Center does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from The Kovner Center within 30 days of receiving your written request. Under certain circumstances, The Kovner Center may feel it must deny your request, but if it does, The Kovner Center will give you, in writing, the reasons for the denial. The Kovner Center will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the

fees associated with supplies and postage. The Kovner Center may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that The Kovner Center limit how it uses and discloses your PHI. While The Kovner Center will consider your request, it is not legally bound to agree. If The Kovner Center does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that The Kovner Center is legally required or permitted to make.

3. The Right to Choose How The Kovner Center Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). The Kovner Center is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that The Kovner Center has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include

disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6 year period and starting after April 14, 2003.

The Kovner Center will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. The Kovner Center will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Choose Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that The Kovner Center correct the existing information or add the missing information. Your request and the reason for the request must be made in writing.

You will receive a response within 60 days of The Kovner Center's receipt of your request. Management Institute may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than The Kovner Center. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and The Kovner Center's denial will be attached to any future disclosures of your PHI. If The Kovner Center approves your request, it will make the change(s) to your PHI. Additionally, The Kovner Center will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

7. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

8. Submit all Written Requests: Submit to Dr. Kovner, the Center's Director and Privacy Officer, at the address listed on the bottom of the page.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision The Kovner Center made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. The Kovner Center will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint. Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. The Kovner Center's Responsibilities: We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Date of Last Revision: 08/12/18



*Steven Kovner, Ph.D.,
Licensed Psychologist
and Director*

TELEPSYCHOLOGY INFORMED CONSENT

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. If a need for direct, face to face services arises, it is my responsibility to contact his office for a face to face appointment. I understand that an opening may not be immediately available.
3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.
4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
 - a. I understand that the Kovner Center does not provide 24/7 emergency coverage. In the event of an emergency situation I will contact the emergency operator by calling 911, call the National Suicide Prevention Lifeline at 800-273-8255, or go to my local hospital emergency room.
 - b. Should service be disrupted you will not be billed for the service and an attempt will be made to reconnect you with your therapist by calling you on your cell phone to complete the session.
 - c. For other communication, the Kovner Center will only communicate administrative matters with you, such as booking appointments or sending you educational/therapeutic materials that contain none of your private health or mental health information. Since your Email may not be safe and could be subject to hacking or theft, we advise you not to send clinical information over through your email unless you know that it is encrypted and compatible with the HIPAA standards of privacy. If you do send information to me using your email, you assume all responsibility for any breach or theft of your information.

6. My psychologist/therapist will respond to communications and routine messages within 24 hours.
7. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
8. My communications exchanged with my psychologist/therapist will be stored in the office located at 4046 Wetherburn Way, Suite 7, Peachtree Corners, Georgia 30092 and kept for 10 years.
9. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

 Signature of Parent or Legal Guardian
 (Printed name will represent client's electronic
 signature)

 Date

 Signature of Parent or Legal Guardian
 (Printed name will represent client's electronic
 signature)

 Date