Tarboro Pediatric Psychology

511 Saint Andrew Street
Tarboro, NC 27886
(252) 823-6187
Fax (252) 641-0715

Welcome to Tarboro Pediatric Psychology!!

BUSINESS POLICIES

This brochure about our office policies and procedures has been developed to provide answers to questions about appointments, messages, emergencies, insurance, and confidentiality. Please review it carefully. If you have questions or concerns, feel free to discuss them with me. At the initial appointment, you will be asked to sign a "Consent for Treatment" which will become part of your file.

APPOINTMENTS

Hours are by appointment only. To schedule, cancel, or change an appointment, please call our main office number at 823-6187. Because we do not have office support at all times, please leave a message with your name, your child's name, and a number where we can reach you. It is very important that you make every effort to keep your scheduled appointment. ***There will be a charge of $50 for missed appointment unless notice of cancellation is received at least 24 hours in advance.*** In addition, we cannot guarantee that you will be rescheduled for another appointment if you miss your appointment without giving us sufficient notice. Missed appointments are not reimbursed by insurance.

CHARGES AND INSURANCE

Our psychologists are contract providers with BCBS, MedCost, and NC State Health Plan. We are glad to check your benefits to determine what your mental health benefits cover. However, we cannot guarantee that your insurance will cover our services and therefore, it is your responsibility to contact your insurance carrier to find out about benefits. You are responsible for all fees not covered by your insurance company. It is also your responsibility to determine if any pre-authorization or pre-certification is needed before your first appointment. Pre-authorization paperwork must be completed with a decision made by your insurance company prior to your first testing visit. If pre-authorization was required and not obtained by you, you understand that you will be fully responsible for your account balance and that your insurance company may not provide reimbursement for the services rendered.

MESSAGES

Although we are in our offices during business hours, we are often not immediately available by telephone. However, we make every attempt to return calls as soon as we can. Due to the volume of calls that we receive, it may take 2-3 days to return your call, although many times we are able to return them the same day. Please leave a good time for us to try to contact you and phone numbers where you can be reached.

EMERGENCIES

We are not a 24-hour on-call facility. If you have an emergency during office hours, please leave your psychologist a message, and we will call you back as soon as possible. However, if you are not able to

reach your therapist and you or your child needs immediate assistance, you need to call 911 or go to your local emergency room and give the emergency personnel your psychologist's name.

CONFIDENTIALITY

When working with children and adolescents, it is essential that the child or adolescent be able to trust his or her therapist. In that regard, it is appropriate to keep the confidentiality of a child the same way we keep the confidentiality of an adult. As the parent or guardian, however, you have the right and responsibility to question and understand the nature of our activities and progress with your child. We must use our clinical discretion as to what is an appropriate disclosure. In general, we will not release specific information that the child provides; however, it is always appropriate to discuss your child's progress and participation in treatment.

In general, the confidentiality and privacy of all communication between a patient and a psychologist is protected by law and we can only release information about you and your child to others with your written permission. Exceptions to this are outlined in the HIPAA Privacy Form.

Should one of these situations arise, your psychologist will make every effort to discuss it with you before taking any action.

FEES

Initial Diagnostic Interview	$200
Short Therapy Session	$100
Regular Therapy Session	$150
Extended Therapy Session	$200

Psychological testing is a specialized procedure that allows you to understand your child's strengths and weaknesses so that you can seek the most appropriate treatment and school modifications to allow your child to function the best that he or she can. Comprehensive psychological evaluation for conditions such as AD/HD, learning difficulties, and Autism Spectrum Disorder typically involved a diagnostic interview, cognitive testing, achievement testing, parent and teacher-completed behavior ratings, testing specific to assessing for autism spectrum, and a feedback session to review results and recommendations. A comprehensive report detailing on testing data as well as recommendations is also included. Our charges for testing are as follows:

Diagnostic Interview	$200
Psychological Testing	$200/hour (usually 6-10 hours)
Feedback Session	$200

Insurance plans differ in how they reimburse for psychological testing and before scheduling your child for testing, we can determine what is likely to be covered by health insurance. What you will be responsible for is determined by your benefits, your deductible and copay.
/
If you have any questions about these policies, please do not hesitate to contact us. We will make every effort to answer your questions!

We look forward to working with you and your child!

Tarboro Pediatric Psychology PLLC

Patient Information

Patient Name _____ Psychologist _____

Today's Date _____ Date of Birth _____

Gender _____

Parent/Guardian _____
(if applicable)

Mailing Address _____

City/State/Zip _____

Responsible Party _____
(guarantor)

Contact Number(s) Home _____ May we leave a message? _____

Work _____ May we leave a message? _____

Cell _____ May we leave a message? _____

Employer _____

Name of School _____ Telephone _____
(if applicable)

Insurance Provider _____

Policy # _____ Group # _____

Physician's Name and Telephone # _____

Email: (***we may need this to contact you***)

Presenting Problems:

Therapy	***Psychological Testing***
o Anxiety, OCD, Separation, Worry)	o AD/HD
o Depression	o Autism Spectrum Disorder
o Parental Divorce/Separation	o Learning Disorder
o Eating Disorders	o Processing Problems
o Behavior Problems	o Other: _____
o Other: _____	

Are there current legal proceedings involving custody, visitation, or divorce? If yes, please explain:

When we contact you, we will obtain more detailed information about presenting concerns and whether therapy or testing is needed. We look forward to working with you!

Tarboro Pediatric Psychology PLLC

NOTICE OF PRIVACY PRACTICES

This notice is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that we protect the privacy of health information that identifies a patient. This Notice describes your rights as our patient and our obligations regarding the use and disclosure of Protected Health Information (PHI). PHI is information about you, including demographic information, that my identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Tarboro Pediatric Psychology has a responsibility to 1) maintain the privacy of your health information, 2) provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you, 3) abide by the terms of this Notice, 4) notify you if we are unable to agree to a requested restriction or amendment to your record, 5) accommodate reasonable requests you may have made to communicate health information by alternative means or at alternative locations. Please note that Tarboro Pediatric Psychology reserves the right to change our practices and to make the new provisions effective for all PHI we maintain, as well as any information we receive in the future. Before any changes, Tarboro Pediatric Psychology will immediately change this Notice and post a new copy in our office. You may request a copy of this Notice from Tarboro Pediatric Psychology.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your psychologist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other uses required by law.

A. **Treatment:** Tarboro Pediatric Psychology may use and disclose PHI about you to provide, coordinate, or manage your health care and related services. This includes the coordination of your health care with a third party. This may be to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. For example, if a psychiatrist or physician is treating you, Tarboro Pediatric Psychology may disclose your PHI to him or her in order to coordinate your care.

B. **Payment:** Tarboro Pediatric Psychology will use or disclose PHI so that we can bill and collect payment for the treatment and services. This may include insurance companies, billing companies, claims processing companies or collection agencies.

C. **Healthcare Operations**: Tarboro Pediatric Psychology may use your PHI to evaluate the performance of the health care professionals who provided you with these services. This sometimes occurs in an effort to improve quality and effectiveness of care. These activities may include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may call you by name in the waiting room when the psychologist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

D. **Emergencies:** Tarboro Pediatric Psychology may use your information in case of an emergency to assist in your treatment. For example, the practice may relay PHI to the Emergency Department if it is decided that it is necessary for the well-being and safety of the patient.

E. **Other Uses and Disclosures:** Tarboro Pediatric Psychology may use or disclose your PHI to other resources such as transcription services, HIPAA officials, and/or other legal representatives that evaluate that we are following such said policies.

2. Uses and Disclosures that do not require consent

We may use or disclose your PHI in the following situations without your authorization. These situations include: Legal Proceedings, Abuse, Neglect, or Domestic Violence, Law Enforcement, Research, Worker's Compensation, Health Oversight Activities, Coroners Information.

3. Patients' Rights to PHI

A. The right to see and get copies of your PHI: The patient has the right to see or get a copy of PHI via a written request. You will get a response within 30 days beyond the day the written request is received. There will be a fee of no more than $.25 per page. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

B. The right for the patient to amend their PHI: A patient may request in writing to amend their health record along with reasonable explanation for the request.

   a. The right to request restrictions on certain uses and disclosures of PHI: The patient has the right to request restrictions on uses and disclosures of PHI via written format. For example, the patient may restrict information to family members, relatives, friends or other resources such as insurance companies. We are not required to agree with your request.
   b. The patient has the right to obtain an accounting or disclosures of your PHI via written request.
   c. The Right to request, in writing, communications of your PHI by alternative means or at alternative locations.

C. The right to file a complaint. If you believe your privacy rights have been violated, you can discuss and/or file a complaint with Tarboro Pediatric Psychology or with the Secretary of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201.

Effective Date of this Notice is January 6, 2016. Signature below is only acknowledgement that you have reviewed this Notice of our Privacy Practices.

_____ _____

Patient's Signature Date

_____ _____

Signature of Patient's parent/guardian Date

Tarboro Pediatric Psychology PLLC

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION PURPOSES

Patient Name _____ Date of Birth_____

I give my voluntary consent for Tarboro Pediatric Psychology PLLC to use
(Name of Provider)

and disclose health information regarding _____
(Patient Name)

to the following agencies/individuals when applicable for purposes of treatment*, payment** (including benefit payment and for establishment of entitlements) and health care operations***: Medicaid, Medicare, State Employee Health Plan, Disability Determination Office, Blue Cross/Blue Shield, any other health or benefit program for determination of coverage and for disclosure of information related to payment activities including collections agencies, and any of the following agencies/individuals not listed above:

_____
_____.

I also consent for you to disclose information relevant to payment activities to the person responsible for payment of my bills (guarantor) if different from myself _____.
(Guarantor Name)

I understand that state and federal laws permit certain uses and disclosures for treatment, payment, and health care operations without my consent and these have been explained in the *Notice of Privacy Practices* that has been provided to me. I understand that the health information used and disclosed may include information such as HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, if applicable.

I understand this consent is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for payment purposes, wherein the consent is valid until the need for disclosure is satisfied. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that I will be asked to sign the *Revocation Section* at the bottom of this page. I further understand that any action taken on this consent prior to the rescinded date is legal and binding.

A copy of this consent shall be considered as valid as the original.

_____	_____	_____
(Signature of Patient)	*(Date)*	*(Witness Signature-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

(Staff Use Only)

NOTE: This Consent was revoked on: _____ _____
(Date) *(Signature of Staff)*

Tarboro Pediatric Psychology PLLC

**Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

***Payment* means to obtain or provide reimbursement for the provision of health care; determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing; review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; and disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; Social Security Number; payment history; account number; and name and address of the health care provider and/or health plan.

****Health Care Operations* include conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and clients with information about treatment alternatives; related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; business planning and development such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, and development or improvement of methods of payment or coverage policies; and business management and general administrative activities of the entity, including, but not limited to: management activities relating to implementation of and compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; resolution of internal grievances; the sale, transfer, merger, or consolidation of all or part of a covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and creating de- identified health information and fundraising for the benefit of the covered entity.

Tarboro Pediatric Psychology PLLC

Patient Consent for Treatment

I understand and accept the information provided concerning business policies and procedures, appointments, fees for services and no-show, emergencies, and confidentiality. I understand that I have the right to withdraw consent at any time. If this release is being signed by a guardian of a minor, the guardian hereby acknowledges and affirms that s/he is the current *legal guardian* empowered under North Carolina law. The undersigned hereby agrees that s/he shall keep Tarboro Pediatric Psychology apprised of any potential or actual changes in this legal guardianship.

_____

Patient/Legal Guardian Signature Date