necca
Neuropsychology and Educational Clinic for Children and Adolescents
Specializing in Diagnosis and Treatment
Karen P. Kelly, Ph.D.
484.557.5666

Neuropsychology and Educational Clinic for Children and Adolescents

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EVALUATION CONTRACT

For Services Regarding:

Name _____
Address _____
_____
Date of Birth _____

Psychologist-Patient Services Agreement

Welcome to the practice of Dr. Karen Kelly of Wayne, PA. This document contains important information about professional services and business policies. The evaluation involves a comprehensive analysis of your child and requires reviewing the medical, social, occupational, family, and mental health history of your child. We ask that you request records from other provides that are or have been involved in your child's care and bring them to your appointment.

PROFESSIONAL FEES and SERVICES
The fee for an IEE or comprehensive neuropsychological evaluation for children is $4,800. This fee includes the following: an initial clinical interview, a comprehensive evaluation (typically lasting a full day), scoring, report writing, and a feedback session. If a classroom observation is needed, the fee is $5.300. The fees for an attention/processing evaluation are $2400. All fees are expected to be paid in full by the day of the evaluation. It is important to note that evaluation and services for educational assessment are typically not covered by insurance.

MINORS & PARENTS
Children (under age of 18) and their parents should be aware that the law may allow parents to examine their child's records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. By presenting your child for services, you are representing and affirming that you have legal parental authority to do so. Unless parental rights have been terminated or restrictions have been set forth by the court or law, you are affirming that both parents have legal rights to information about diagnosis and treatment under the law.

LIMITS ON CONFIDENTIALITY
The law protects the privacy of all communications between a patient and a psychologist, although some situations are excluded by law. In most situations we can only release information about your treatment to others if you sign a written Authorization form including certain legal requirements outlined by HIPPA and/or Federal or State Law.

There are other situations that require only that you provide written advance consent. Your signature on this agreement provides consent for the listed services above. Occasionally it may be helpful to consult with other health and mental health professionals about a case. During such a consultation, every effort is made to avoid releasing identity of the patient. However, such consultations will not be made known to you as they are conducted with other professionals who are also bound to confidentiality standards. Protected Health Information may be used or disclosed in supervised training within the office where psychology residents, assistants, interns, or trainees learn to practice psychological or neuropsychological evaluations.

We may use personal health information to conduct or participate in research studies based upon the clinical and health records kept in archives. In such cases, any personal identifying information shall be removed from any data sets created. Such research would be contingent on the implementation of confidential and ethical guidelines.

In some situations, Dr. Kelly is required or permitted to disclose information without your consent or authorization. Please note below:

- If you are involved in a court proceeding and a request is made for information regarding services provided to your child, such information is protected by the psychologist-patient privilege law. Dr. Kelly cannot provide any information without your written authorization, a court order, or if Dr. Kelly receives a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or considering litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- Also, if a government agency is requesting the information for any health oversight activities, Dr. Kelly may be required to provide it for them.
- Dr. Kelly is legally required to share private information and take action in situations where it is necessary to attempt to protect others from harm:
- If Dr. Kelly knows or suspects that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that we file a report with the Department of Child and Family Services. Once such a report is filed, we may be required to provide additional information.
- If Dr. Kelly knows or suspects that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that I file a report with the central abuse hotline. Once this report is filed, Dr. Kelly may be required to provide additional information.
- If Dr. Kelly believes or suspects that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or the appropriate family member, and/or the police or seeking hospitalization of the patient.
- If such situations arise, Dr. Kelly will make a reasonable effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

PATIENT RIGHTS

HIPPA provides you with new or expanded rights with regard to your Clinical Records and disclosures of PHI (protected health information). Please review the Notice and contact my office, if desired.

PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

Your signature below indicates that your have read and understand the information in this document and have had an opportunity to ask any questions, and agree to abide by its terms. Your signature also indicates that your have reviewed the HIPPA Notice form.

_____

Parent or Legal Guardian Name (printed)

_____ _____

Parent or Legal Guardian Name Signature Date

Karen P. Kelly, Ph.D.