Patient Information

Patient's Name: _____

Date:_____Birthdate: _____

Age:_____Gender:_____Ethnicity:_____

Address: _____

City, State, ZIP: _____

Referred by: _____

How did you learn about Dr. Shouse's practice? (circle all that apply)

Google search	Good Therapy.org	A Psychiatrist
Yahoo search	Family Doctor	Another Therapist/Psychologist
Psychology Today	School	Other_____

Occupation (if applicable):_____

Highest Education Completed: _____

Home Phone: _____

Cell Phone: _____

Email:_____

What phone number/method is best for communication with you:

Home_____Work_____Cell Phone_____Email _____

Is it okay to leave a message for you at your preferred number? Yes_____ No_____

Is it okay to contact you via email for scheduling purposes? Yes____No____

Emergency Contact:

Name: _____

Relationship: _____

Cellular #_____Home # _____

Who Is Financially Responsible for this account? Who is the insured?

Name: _____

Relationship to Patient: _____

Date of Birth of Policy Holder: _____

Driver's License# _____

Address (if different than patient):

_____

City, State, Zip:

_____

Employer: _____

Occupation: _____

Authorization and Release:

- I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- I authorize the release of necessary information to Verdant Oak Behavioral Health, Inc., administrator.
- I am informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- I agree to be responsible for payment of all services rendered on my behalf or for my dependents.
- I agree to notify your office more than 24 business hours in advance if I need to reschedule or cancel an appointment.

X_____

Signature and Printed Name of Responsible Party **Date**

Elizabeth Shouse, Psy.D. (PSY27796)
1151 El Centro St.
Suite B
South Pasadena, CA 91030

Informed Consent for Psychological Assessment and Agreement to Pay

This document provides you with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA pre-emptive analysis. It explains several important aspects of assessment provided by Elizabeth Shouse, Psy.D. (PSY27796). Although this document is lengthy, it is important that you read through it thoroughly and ask any questions you may have.

CONFIDENTIALITY

Information about your assessment is confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Below is a *non-exhaustive* list of circumstances when disclosure is, or, may be, required by law. The list is not exhaustive because the laws in this area change from time to time. However, the list is designed to give you an idea of some of the circumstances where disclosure may be required.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are:

- If Dr. Shouse has any knowledge, or suspicion, of child, elderly, or dependent adult abuse or neglect, the law requires that she file a report with the appropriate government agency. This mandate includes if you reveal any instances of abuse or neglect on the part of yourself, others you know, family members, etc. Domestic violence in some instances is also considered reportable when observed by children. In most instances, Dr. Shouse will discuss the necessity of filing a report before she does so.
- If you become a danger to yourself, to others, to property, or when your family member communicates to Dr. Shouse that you present a danger to others, or you become gravely disabled, Dr. Shouse may have to reveal information about you to other mental health professionals, family members, identified victims, and/or emergency services.

******* While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have with Dr. Shouse. As you might suspect, the laws governing these issues are quite complex and Dr. Shouse is not an attorney. While she is happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, Dr. Shouse will provide you with relevant portions or summaries of the applicable federal and/or state laws governing these issues.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the medical records and/or testimony by Dr. Shouse. If ordered to do so by a judge, Dr. Shouse may have to release protected health information to the court. Additionally, if a client files a complaint or lawsuit against Dr. Shouse, relevant information regarding that client may be disclosed for Dr. Shouse's defense.

Litigation Limitation: It is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorneys, nor anyone else acting on your behalf, will call on Dr. Shouse to testify in court or at any other proceeding, nor will a disclosure of the confidential records be requested unless otherwise agreed upon.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Dr. Shouse has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future ability to obtain insurance, other benefits or even a job. The risk stems from, among other things, the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database always carries some risk because computers are inherently vulnerable to break-ins and unauthorized access. Medical data has also been reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.

Consultation: It may be necessary to consult with another mental health professional. In this instance, every effort is made to keep your identity confidential during the consultation, and these professionals are also required to maintain confidentiality.

Emails, Cell Phones, Computers and Faxes: It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, Dr. Shouse's e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address. Please notify Dr. Shouse if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or faxes. If you communicate confidential or highly private information via e-mail, Dr. Shouse will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies.

Records and Your Right to Review Them: Both the law and the standards of Dr. Shouse's profession require that she keeps appropriate treatment records for at least seven years. Unless otherwise agreed necessary, Dr. Shouse retains clinical records only as long as is mandated by California law. If you have concerns regarding the treatment records, please discuss them with Dr. Shouse. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Dr. Shouse assesses that releasing such information might be harmful in any way. In such a case, Dr. Shouse will provide the records to an appropriate and legitimate mental health professional of your choice.

Considering all of the above exclusions, if it is still appropriate, upon your request, Dr. Shouse will release information to any agency/person you specify.

PURPOSE OF ASSESSMENT

The purpose of a psychological assessment is to identify strengths and weaknesses in various domains and to develop new strategies, accommodations and/or adaptations that may help improve your [child's] learning. Domains assessed might include, but may also not be limited to:

- Cognitive Ability (e.g. ability to reason and process information, attention)
- Memory (i.e. short-term, long-term, and working memory)
- Academic Achievement (i.e. reading, writing, spelling, and math)
- Perceptual Abilities (i.e. visual perception, motor coordination, and visual-motor integration)
- Adaptive Functioning (i.e. life skills)
- Behavioral, Social, and Emotional Functioning (e.g. personality, interpersonal functioning)

ASSESSMENT PROCESS

First and foremost, you should understand that an assessment is NOT a guarantee of receiving a diagnosis or disability accommodations.

If applicable, it is the client's responsibility to obtain the necessary information required for Dr. Shouse to perform the assessment consistent with the standards of your institution. It is also helpful if you can provide contact information for the agency you wish to submit the report to, so that Dr. Shouse can follow up with any questions if necessary. This will also require you to complete a written release of information so that Dr. Shouse may communicate with said agency.

Most assessments require a significant amount of information from the client in addition to the testing performed in the office. Dr. Shouse might request that you obtain school records, prior testing reports, IEP/504 reports/plans, and any other relevant documentation to your testing concern. She may also request you sign release forms so that she can obtain information from other relevant individuals, such as parents/caretakers, school officials/teachers, and physicians or other treatment providers. This information will help Dr. Shouse obtain a complete picture of how you are performing in school, work, and home environments, which will assist in providing the most accurate diagnosis and recommendations.

In addition to the lengthy interview and information gathering described above, you will be asked to complete a variety of standardized tests in the office. The specific tests you will be asked to complete will depend on the problems/concerns you describe to Dr. Shouse. She tailors her assessments to each individual, so it is possible you will be asked to return to her office after she has had the opportunity to score some of your tests. Sometimes she finds it necessary to request additional information or testing before drawing conclusions about your difficulty.

Dr. Shouse collaborates with other psychologists contracted with VOBH to provide psychological technician services. Said individuals may be asked to administer assessment tests following the initial intake. Psychological technicians are not responsible for the final results of your report, and any questions or concerns you have related to the outcome of testing should be directed to Dr. Shouse.

REPORT TIMELINE AND FEEDBACK

Given the varying number of clients seen by Dr. Shouse each week, she cannot guarantee a particular timeline for a report. If you need an assessment completed by a specific date, she may recommend that you obtain the assessment from a different provider. Please discuss this issue with Dr. Shouse at your first appointment. In general, Dr. Shouse makes an effort to complete reports by four (4) weeks after your final assessment appointment.

You should understand that much of the information you reveal to Dr. Shouse will be described in the report. While she makes an effort to only include information that is relevant to making or ruling out a diagnosis (e.g., she would not describe a traumatic event that occurred in your life if it did not relate to your diagnosis, and even then she would make an effort to protect your confidentiality), she cannot guarantee that information will or will not be included in the report.

When the report is completed, she will contact you and request an appointment for a feedback session. During the feedback session, Dr. Shouse will provide you with a detailed account of your testing results, diagnostic conclusions, and recommendations. This is a great opportunity for you to ask any questions you have about the report as well. Dr. Shouse does not issue the report without a feedback session; it is essential to convey the information directly to the client since reports often use technical language.

APPOINTMENTS

The length and number of assessment sessions vary widely. Your schedule, Dr. Shouse's schedule, and your ability to concentrate for extended periods of time are all taken into account in determining the length of assessment sessions. Typically, however, a time period of at least two (2) hours is needed for each appointment. Missed sessions and late arrivals are problematic for both clients and Dr. Shouse. Therefore, she asks clients to make a commitment to attend all of their scheduled appointments to complete the assessment as quickly as possible. Office policies regarding missed and late appointments are as follows:

1. You should provide at least 24 hours advance notice of cancellation. Failure to do so will result in being charged for your missed appointment.
2. If you are more than 20 minutes late without prior notice, Dr. Shouse will assume that you have had to cancel the session and may leave the office if you are the last appointment of the day.

3. If you have cancelled or missed a session, it is your responsibility to contact Dr. Shouse to reschedule.

FEES, PAYMENTS & INSURANCE REIMBURSEMENT

The standard fee for the initial diagnostic interview will be $225. Thereafter, the standard **hourly** fee agreed upon for this evaluation is $175. This fee will be applied to all assessment appointments, all outside consultations (e.g., telephone conversations, Dr. Shouse speaking to parents, schools, doctors), record review, scoring and interpretation of test results, writing the report, and a feedback session to explain the results to you. As it is difficult to identify an exact number of hours for administration, scoring, interpretation, report writing and feedback, an *exact* cost cannot be determined at the outset. However, Dr. Shouse will do her best to provide you with an estimate of the total cost. If you are using insurance, you are encouraged to speak with your provider about your coverage for psychological testing.

Verdant Oak Behavioral Health, Inc. (VOBH) is the administrative agent responsible for all billings and scheduling for Dr. Shouse. Clients are expected to pay their standard agreed upon fee to VOBH at the end of each appointment unless other arrangements have been made. Please notify Dr. Shouse if any problems arise during the course of assessment regarding your ability to make timely payments. Clients who use insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, VOBH will file a claim with your insurance company as a courtesy to you or provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section *Health Insurance & Confidentiality of Records,* you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. There is not a guarantee that psychological assessment is reimbursed by your insurance company. It is your responsibility to verify the specifics of your coverage. If any claim is unpaid, you are responsible for the balance due. If your account is overdue (unpaid) and there is no written agreement on a payment plan, VOBH, as Dr. Shouse's agent, can use legal or other means (courts, collection agencies, etc.) to obtain payment. Dr. Shouse also reserves the right to suspend and/or terminate services if your account is overdue and no other arrangements are made.

CREDENTIALS AND LICENSE

Dr. Shouse earned a Doctorate in Clinical Psychology from Alliant International University in Alhambra, CA in 2013. She is a licensed psychologist in California (PSY27796).

COMPLAINTS

Dr. Shouse is dedicated to establishing a safe environment that fosters open and honest communication. You may terminate services at any time. You are invited to discuss any concerns you may have about your [child's] assessment or the services provided with Dr. Shouse. Every client has the right to complain if he/she feels he/she has received unethical services. The Department of Consumer Affair's Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board on the Internet at www.psychboard.ca.gov, by calling 1-866-503-3221, or by writing to the following address: California Board of Psychology, 1625 N. Market Blvd., Suite N-215, Sacramento, California 95834.

SIGNATURE

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. **Please initial the items below,** which highlight the major points of this document to which you are agreeing. If you have any questions or are unclear about any policy, please feel free to discuss with Dr. Shouse.

- _____ I have read and understood the limits to confidentiality.
- _____ I have read and understood the policies about missed appointments/cancelling without advance notice, and I understand that failure to cancel appointments appropriately will result in being charged for the session.
- _____ I understand that this assessment is voluntary and I can withdraw [my child] from this assessment at any time.
- _____I have discussed fees with Dr. Shouse and agree to pay the hourly rate indicted above, which will be applied to the time spent during intake, administration of tests, scoring, interpretation, report writing, feedback, and collection of any additional collateral information.

Client Name (print)	Date	Signature

Guardian Name (print)	Date	Signature

Elizabeth Shouse, Psy.D.
PSY27796

Psychologist	Date	Signature

Elizabeth Shouse, Psy.D.
1151 El Centro St.
Suite B
South Pasadena, CA 91030
Lic. #: PSY27796

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization and its administrator, Verdant Oak Behavioral Health, Inc. originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means for Verdant Oak Behavioral Health, Inc. to bill for services rendered
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature_____

Date: _____

Witness_____

Date_____

Verdant Oak Behavioral Health, Inc.

1151 El Centro St., Ste B.
South Pasadena, CA 91030

Credit Card Authorization

Please make no marks nor add any comments to this page of the document. It is your consent to make payment for services rendered, and your treatment is conditional upon your signing of this consent form without modification. This form will be securely stored in your clinical file and may be updated at any time upon request.

You may opt out of leaving a credit card on file with us; however, you will then need to leave a cash or check deposit in the amount equivalent to full fee for two therapy sessions or in the amount of $450 for testing/assessment services.

In the event that you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

An additional $25 fee will be assessed for: 1) returned checks, and/or 2) inaccurately disputed charge-backs.

I,_____, hereby authorize Verdant Oak Behavioral Health, Inc. to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- **Missed appointments**
- Telephone and email consultations
- Appointments that I have cancelled with less than 24 business hours notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

☐ Visa ☐MasterCard ☐Discover ☐ American Express

Card #_____Expiration Date: _____

Verification/Security Code (3 or 4-digit code on back of card by signature line): _____

Name as Printed on Card: _____

Billing Address: _____

City:_____State:_____ZIP: _____

By signing below I am authorizing Verdant Oak Behavioral Health, Inc. to bill my credit card at the usual fee for professional services as described above.

Signature: _____ Date: _____