Hopewell Neuropsychological Center

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INFORMED CONSENT

Overview of Services:

At Hopewell Neuropsychological Center (HNC), we offer comprehensive evaluations that involve **two** key steps:

1. **Assessment:** During the assessment, our team of professionals will gather information about you through interviews, questionnaires, and standardized tests. This helps us understand your cognitive functions, such as memory, attention, and problem-solving, as well as your emotional well-being and daily functioning.
    - It typically takes 2-5 hours and in some cases ***may*** take a whole day, or multiple sessions
    - Your active participation and best effort during testing are crucial to ensure the accuracy and reliability of the results
2. **Evaluation Report**: After the assessment, Dr. Hopewell will review your results, considering your background and individual circumstances. By carefully evaluating your performance on the tests and interview, Dr. Hopewell can create a complete picture of how your brain functions and how it might be impacting your daily life. This will include explanations of your cognitive strengths and weaknesses, along with recommendations for treatment, coping strategies, or resources.
    - It takes a minimum of 21 business days for HNC to evaluate the findings, process and send your report back to your referring provider/organization
    - Follow up appointments with Dr. Hopewell are optional, but recommended for self-referral or if you need a more detailed explanation of the evaluation report and recommendations

Benefits of Assessment & Evaluation:

- **Accurate Diagnosis:** The evaluation can help pinpoint potential underlying causes for any cognitive or behavioral concerns you may be experiencing
- **Informed Treatment Planning:** Through an evaluation that tailors treatment approaches to your individual needs by understanding your specific strengths and weaknesses in different cognitive areas, your team of healthcare providers can create a personalized treatment plan designed to maximize your well-being
- **Monitoring Progress and Outcomes:** The evaluation can serve as a baseline to track your progress over time and ensure your treatment plan remains effective

Your Comfort and Privacy Are Our Priority:

We recognize that undergoing an evaluation can be a new experience. We are dedicated to creating a comfortable and supportive environment throughout the process. At our practice, we ensure patient and staff safety with video surveillance in key areas such as the lobby, front, and back door. Recordings at our practice are securely stored for 7 days and accessed **only for authorized security purposes.**

The assessment and evaluation process may be distressing and may affect you emotionally. Our staff can provide you with a list of resources and helplines if you are facing emotional distress.

Patient Name _____

Date of Birth _____ Age: _____

Informed Consent Agreement

I ,_____, give permission to Hopewell Neuropsychological Center, and its employees or agents to provide clinical services and treatments as needed for myself and/or my minor child. I acknowledge that I am fully informed about the relevant reasons for requesting the evaluation and have a clear understanding of the services that will be provided. Initials _____

I understand that testing time can vary and ***may take anywhere from 2 to 5 hours***, and in some cases ***may take a whole day, or multiple sessions*** to capture pertinent information. Initials _____

I understand that if I take multiple sessions to test, then I need to complete ***all tests within 2 weeks of my initial test date*** or my assessment will be processed as is. Initials _____

I understand that the evaluation report will be sent back to referral source when applicable. Initials _____

I consent to the confidential use of my evaluation for research for professional and scientific purposes, as long as the information is **NOT** associated with any of my personally identifiable information. Initials _____

Medical Records

By initialing this section, I agree to the following statements:

- I understand that an evaluation report will be written after my assessment and that a copy of that report will be sent to Advantage Healthcare Systems
- I understand that if I want a copy of my evaluation report, then I must contact Advantage Healthcare Systems
- While I retain the right to request a correction within **ONE year of the testing date** for any perceived inaccuracies in the report, the **final decision** to rectify it lies with HNC/ Clifford Alan Hopewell, Ph.D., MP, ABPP Fellow
- I understand that it is my responsibility to provide accurate information during my evaluation and any inaccuracies or omissions on my part are not the responsibility of HNC/Clifford Alan Hopewell, Ph.D., MP, ABPP Fellow
- I am aware that Clifford Alan Hopewell, Ph.D., MP, ABPP Fellow reserves the right to determine if an individual patient may receive records or reports under Texas law. Raw data will only be released through a legal subpoena or court order by a qualified neuropsychologist. Initials _____

Consent for Evaluation and Treatment

By signing, I affirm that I understand that I am consenting for assessment and evaluation from Clifford Alan Hopewell, Ph.D., MP, ABPP Fellow for myself, _____. I further affirm that I understand and agree to the policies outlined in this packet, as indicated where I initialed.

I provide consent to Hopewell Neuropsychological Center, to render services and I agree to the policies outlined in this packet as indicated where I initialed.

Signature: _____ Date:_____

CONSENT FOR TELEHEALTH SERVICES FORM

This informed consent has important information regarding your telehealth services. Please read over it carefully and let a staff member know if you have any questions.

Overview of Telehealth Services

Telehealth services at Hopewell Neuropsychological Center (HNC) is the practice of delivering clinical health care services via technology assisted media or other electronic communication means (e.g. internet or phone) between a provider, authorized personnels and a patient who are located at different locations.

Telehealth services improve access to neuropsychological health services by allowing a patient to remain in a secure location of their convenience, especially for those who are far away from HNC's physical location. Clifford Alan Hopewell, Ph.D. will be referred to as 'provider' in this form. Telehealth services may be used to facilitate interview, review of records, tests, diagnosis, consultation, treatment, education, care management, and self-management of a patient's healthcare. The provider, HNC and its authorized staff use secure versions of Doxy.me or AthenaOne for video conferencing and Advantage Healthcare Systems and other authorized personnels may use a different HIPAA compliant platform. You must have access to the internet and a device to use telehealth services. As an example, at minimum, a hands-free device with a camera and a microphone is required. HNC will take necessary steps to ensure the patient's privacy, and it is important that the patient find a private, quiet space, free of distractions to avoid interruptions during the telehealth services.

Telehealth Services Policies

- *Recording Policy:* You are NOT allowed to record any remote sessions in any way, unless you and the provider have both consented in writing. Do NOT send, give, or show the tests to anyone other than the provider and/or authorized personnels.
- *Technical Issues Policy:* Telehealth services may stop working during a telehealth service session, if it stops more than twice, then the session may have to end.
- *Emergency Policy:* You are required to inform the provider of your location at the beginning of each session if you are not located at an authorized partner site (Advantage Healthcare Systems). In the event of a life-threatening emergency, the person(s) listed as emergency contact will be contacted to go to your location and/or take you to seek emergency medical care.

Acknowledgment

This consent is an addendum to the informed consent that was agreed to the beginning of service. It does not change any part of that agreement.

I understand the following with respect to Telehealth Services:

- I have the right to confidentiality about my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment.
- In some instances Telehealth services may not be as effective or provide the same results as in-person health services. I further understand that if the provider believes I would be better served by in person health services, it will be discussed with me, and I will be referred to in-person services as needed.
- There is a risk of being overheard by people near me and that I am responsible for using a location that is private and free of distractions.
- Miscommunication between myself and provide/authorized personnels may occur during telehealth services.
- Despite reasonable efforts of the part of Clifford A. Hopewell, Ph.D./Hopewell Neuropsychological Center, there is a possibility that the transmission and/or storage of medical and/or private information could be disrupted by technical failures or interrupted by unauthorized access.

_____	_____	_____
Patient Name	Patient Signature	Date

CONFIDENTIAL PATIENT INFORMATION FORM

Patient Demographics:

Name: _____

Date of Birth: _____ /_____ /_____ Gender: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Ph: _____ Email: _____

Employer's Information:

Occupation: _____ Employer's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician/Manager:

Organization/Practice: _____

Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Ext _____

Fax: _____

Emergency Contacts:

Contact 1 Name: _____

Relationship to Patient: _____

Cell Ph: _____

Contact 2 Name: _____

Relationship to Patient: _____

Cell Ph: _____

Guarantor (Person Responsible for Payment):

Name: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone _____

Confidential Communication:

HNC may call, leave voice mails, and email information regarding the following : report status, test results, and other health related information. By filling, out the information below, I consent to be contacted in the following manner:

☐ Cell: _____ ☐ Home: _____

☐ Leave a detailed message
☐ Leave call back number only

☐ Leave detailed message
☐ Leave call back number only

☐ Email: _____

FINANCIAL POLICY ACKNOWLEDGEMENT AGREEMENT

Thank you for choosing HNC for your care. We prioritize building successful patient relationships and ensuring you understand our financial policies. For details or assistance, please speak to our Practice Manager, Mary at mary@cahopewell.com or at 817-862-7152.

Co-Pays & Payments

All co-payments, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with a billing coordinator. HNC accepts payment by cash, VISA, and MasterCard and offers flexible financing with CareCredit. Please speak with a staff member to learn more about CareCredit if interested. If you haven't met your deductible, or another reason arises, HNC offers a ***discounted self-pay rate of $2,500*** for the evaluation.

Missed Appointments

All patients must complete our "Appointment Policies Acknowledgment Form" prior to getting a scheduled appointment. HNC requires a minimum of 24 hours' notice to cancel or reschedule appointments. Cancellations or reschedules with notices less than 24 hours or missed appointments will result in a $50 fee being charged to the card on file.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, HNC is NOT a party to that contract. HNC will bill your insurance company and to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of patient information (e.g. address, name, etc). Failure to provide complete insurance information may result in patient responsibility for the entire bill.

Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non payable service. We will send you a bill. If you are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Medicare Advance Beneficiary Notice

Medicare covers services they deem as "reasonable and necessary" under section 1862(a) of the Medicare law. If they decide a service isn't covered, then you will be responsible for the cost. If you have supplemental insurance with Medicare, then Medicare will automatically bill your supplemental insurance for the remaining balance after Medicare pays its portion.

Outstanding Balance Policy

To avoid any late fees, you should settle your bill within 30 days of receiving it. If your balance remains unpaid after 90 days, HNC may refer it to a collection agency.

Acknowledgment

By signing this form, I confirm that I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by HNC to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate HNC to extend credit to me for services provided.

_____ _____

Patient or authorized representative name Date

_____

Patient or authorized representative signature

HIPAA NOTICE OF PRIVACY PRACTICES FORM

This notice contains important information about Hopewell Neuropsychological Center (HNC)'s professional services and business policies in the state of Texas. It describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. This notice of Privacy Practices provides information about how HNC may use and disclose protected health information about you.

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

Clifford Alan Hopewell, Ph.D., Hopewell Neuropsychological Center (HNC), or/and its employees or agents may disclose your protected health information (PHI) for the following purpose:

- *Treatment:* We may use your PHI to provide you with neuropsychological assessment and treatment services. We may also disclose your PHI to other healthcare providers involved in your care
- *Payment:* We may use your PHI to obtain payment for the services we provide to you. This may include submitting claims to your health plan
- *Healthcare Operations:* We may use your PHI for our healthcare operations activities, such as conducting quality improvement activities and reviewing the competence of our professionals
- *Appointment Reminders:* We may use your PHI to contact you to remind you of your appointments
- *Public Health Activities:* We may disclose your PHI to public health authorities as required by law
- *Law Enforcement:* We may disclose your PHI to law enforcement officials as required by law
- *Judicial and Administrative Proceedings:* We may disclose your PHI in response to a court order or other legal process
- *Research:* We may use or disclose your PHI for research purposes, but ***only*** after obtaining your written authorization

II. Use and Disclosure

- Clifford Alan Hopewell, Ph.D. may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Clifford Alan Hopewell, Ph.D. is asked for information for the purposes outside of treatment, payment, and healthcare operation, Clifford Alan Hopewell, Ph.D. will obtain authorization from you before releasing this information.
- Clifford Alan Hopewell, Ph.D. will also need to obtain authorization before releasing your psychotherapy notes."Psychotherapy notes" are notes Clifford Alan Hopewell, Ph.D. have made about our conversation during a private or joint session, which Clifford Alan Hopewell, Ph.D. have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
- You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1) Clifford Alan Hopewell, Ph.D. have relied on that authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Limits of Confidentiality Notice

Hopewell Neuropsychological Center (HNC) prioritize keeping your information confidential, there are some situations where Clifford Alan Hopewell, Ph.D., Hopewell Neuropsychological Center (HNC), and its employees or Agents are required to disclose it by law to protect the safety of themselves or others even without your consent. HNC may use or disclose PHI without your consent or authorization in the following circumstances:

- *Threat of Harm:* If you, your child, or your ward indicates intention to harm themselves or someone else
- *Suspected Abuse:* If there is a concern about child abuse or neglect, or abuse of a helpless adult or elder (physical or emotional)
- *Danger to Self or to Others:* If you, your child, or ward appears to be a danger to themselves or others
- *Minor Victim of Crime:* If you are a minor under 18 and are a victim of a crime
- *Court Orders and Legal Proceedings:* If a court order requires us to release information about your report or if you are involved in a lawsuit (civil or criminal) where your neuropsychological functions is a relevant issue

III. Patient Rights & Neuropsychologist Duties

Patient Rights

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Clifford A. Hopewell, Ph.D. is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and Locations:* You have the right to request that we communicate with you about your PHI in a specific manner, such as by mail instead of by phone.
- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy of your PHI in HNC's health and billing records used to decide about you as long as the PHI is maintained in the record. Clifford Alan Hopewell, Ph.D. may deny your request to PHI under certain circumstances.
- *Right to Amend:* You have the right to request a written amendment of PHI within one year of your testing date. Clifford Alan Hopewell, Ph.D. may deny your request.
- *Right to Access:* You have the right to access your PHI. You can request a copy of your neuropsychological records by submitting a written request to HNC.
- *Right to an Accounting of Disclosures:* You have the right to request an accounting of disclosures of your PHI that we have made for other than treatment, payment, or healthcare operations purposes.

Psychologist Duties

Clifford Alan Hopewell, Ph.D. am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. Clifford Alan Hopewell, Ph.D. reserve the right to change the privacy policies and practices described in this notice. Unless Clifford Alan Hopewell, Ph.D. notifies you of such changes, however, Clifford Alan Hopewell, Ph.D. is required to abide by the terms currently in effect. If Clifford Alan Hopewell, Ph.D. changes the notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. Clifford Alan Hopewell, Ph.D. is not required to agree to this restriction, but if he does, HNC shall honor that agreement.

V. Acknowledgement

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Patient or authorized representative name Patient or authorized representative signature

_____

Date signed

RELEASE OF INFORMATION

This form serves as authorization for the use and disclosure of **Protected Health Information (PHI)** is only for the individual or agency named on this form.

You may request your records be sent to additional individual(s) or agencies by sending additional signed copies of this form located on our website (www.cahopewell.com/forms) to cahopewell@cahopewell.com or via fax at 682-312-9821.

Name: _____ DOB: _____

The PHI to be disclosed includes the following for the purposes of collaboration, insurance, continuing care/treatment, and legal:

- Diagnosis
- Progress notes
- Recommendations
- Psychological/Neuropsychological Report

Reason for disclosure:

I, _____, authorize Hopewell Neuropsychological Center to release/exchange by phone, fax, email, or mail my PHI with the following:

Name	Title (Doctor, Family, etc)	FAX #	Phone #

Dates of records to be released: _____

By signing below, I understand that my records contain information regarding my mental health. I give specific permission for this information to be released. I understand that my records are protected under State and Federal law and cannot be disclosed without my written consent.

This authorization expires on _____ or 1 year from the date signed. I understand that I may revoke this authorization in writing at any time.

_____ _____

Patient or authorized representative name Date

_____ _____

Parent/Guardian/authorized representative signature Date