SPECTRUM SERVICES

Dr. Russell Griffiths, Dr. Rahimeh Andalibian, Elliot Rayman (Student Extern)
Spectrum Psychology Inc. - EIN # 92–3627795, 24338 El Toro Rd Ste C, Laguna Woods, CA 92637

Office Policies

Welcome to "our" work!

Thank you for the honor of having us be a part of your journey. We are grateful! Please fill out the form below and read it carefully. Let us know if you have any questions.

Name of Client(s):_____

Birthdate:_____

Email: _____

Phone Number:_____

Address: _____

Confidentiality: Confidentiality is protected by both ethical practice and by law. All information gathered will remain confidential unless there is a formal written release to share or obtain information. Certain conditions under law require that confidentiality be broken. These include:

- Where there is a reasonable suspicion of abuse of children or elderly persons
- Where the client is judged to present a serious danger of harm to himself/herself or others where you make a claim of disability or distress
- Wherein certain legal situations where the court may subpoena a treatment record
- Where services are sought to assist anyone to commit or plan to commit a crime or tort
- HIPAA policies have been attached for your review
- Our assistant may email you bills and/or appointment confirmations. Please inform us if that is not okay with you.
- At times, telepsychology or consultation sessions may be held via Zoom

Licensure and Scheduling:

- Elliot Rayman is a Ph.D. student extern offering assessments under the supervision of Dr. Russell Griffiths who is a Licensed Educational Psychologist (LEP 2541) in CA, and Dr. Rahimeh Andalibian who is a Licensed Clinical Psychologist in CA, NY, and DC (CA: PSY 17643, DC: PSY 1001336, NY: 020040).
- The scheduling program we use has an appointment reminder feature that will send a reminder email to you two days prior to your appointment. To reduce the chance that reminder emails will go into spam folders, please add the email address
  - ➢ appointmentreminders@therapyportal.com to your address book

Payment:

- The hourly rate for an assessment with our student extern is $200/hour
- The assessment battery is individualized and can take anywhere from 6-12+ hours depending on what is needed
- Part of the evaluation time involves direct clinical structured and semi-structured interviews and observations, gathering information from relatives or partners, review of records, gathering data, collaborating with other professionals or family members, and more. The other part of the time is spent scoring, analyzing, interpreting, and formulating individualized recommendations, report writing, formulating a diagnosis, and providing feedback
- We will see you face-to-face for approximately 3-5 hours
- We will spend approximately 2-6 hours on interviewing outside observers, scoring, and report writing
- We will see you face-to-face for a feedback session for approximately 1 hour
- Our assistant will charge your credit card two times per month: first on the 15th and again on the last day of the month
- Each time you are billed, you will be billed for all sessions and report writing that have happened up until that date
- On your credit card, the charge will show up as "Spectrum Psychology Inc"
- A copy of the final written report will be provided once all assessment dues have been paid in full

Please fill out completely

Name on Card: _____

Credit Card Type: _____

Card Number: _____

Expiration Date: _____ CVV Code: _____

Billing Street Address: _____

Billing City / State / Zip: _____

Insurance and Reimbursement:

- We use the CPT code 96130 for psych testing and 96132 for neuropsych testing
- For prolonged sessions (longer than one hour), you will see the additional code +96131
- Report writing and scoring are billed under the same CPT code. The reason for this is so that you can still get reimbursed for every aspect of the assessment
- Please note that our assistant will send you a superbill (invoice that indicates the CPT code and diagnosis code for your treatment) no later than the 7th day of the following month via the TherapyNotes portal, and you can submit that to your insurance for reimbursement if you have out-of-network coverage. Most of our clients are reimbursed anywhere from 30-90% of their session fees. Signing this consent means that you are **approving our assistant** to have access to your medical records indicating the session date and time you attended so she can prepare your superbill for you. If this is not something you would like to do, please let us know at your first session. Thank you.

PLEASE CHECK ONE OF THE FOLLOWING:

_____ I would like to receive a MONTHLY superbill to submit to my insurance.

_____ I would like to receive ONE final superbill at the end to submit to my insurance.

_____ I plan to pay out of pocket and do not need a superbill. I would prefer a simple invoice.

Cancellation Policy:

- Cancellations must be made **48 hours in advance** or full session fees will be charged. If you are more than **15 minutes** late and have not communicated with us via phone or text that you are running late, we may leave the office, and it will count as a missed session with fees still being charged.

Please feel free to contact us or ask any questions that you may have after reading this form. We are happy to have you here! Welcome!

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(if client is a minor)

PLEASE INITIAL THE FOLLOWING:

_____ I understand that my credit card will be charged two times per month, once mid-month and once again at the end of the month, and that charges will show up from **Spectrum Psychology Inc**

_____ I understand that the amount I will be charged may include more than direct sessions with the extern and may include time spent analyzing data and writing the report.

_____ I understand that I will receive **one invoice each month** in the form of a superbill. I will receive the superbill/invoice in the first week of the following month. The superbill/invoice will include all time billed, diagnosis codes, and insurance CPT codes.

_____ I understand that my providers at Spectrum Services may collaborate internally for the benefit of my care, and that my information may be shared with other psychologists, therapists, and coaches who work at this practice.

Outside Observer Authorization Form

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

We like to include information from an outside observer(s) that knows you well and would be willing to complete some brief questionnaires and provide any additional information that will help us understand you better from their perspective (e.g., spouse if you are married, significant other, parent(s), sibling(s), teacher(s), coaches or therapists, close friend(s), etc.).

I AUTHORIZE SPECTRUM SERVICES AND THE FOLLOWING INDIVIDUALS AND/OR ORGANIZATIONS TO DISCLOSE THE ABOVE NAMED INDIVIDUALS MEDICAL/ EDUCATIONAL INFORMATION AS DESCRIBED BELOW.

Individual/Organization, Address, Phone/Fax #:

_____,

_____,

_____,

- **Duration**: This authorization shall become effective immediately and shall remain in effect until _____/_____/_____ or for one year from the date of signature if no date is entered.
- **Revocation**: I understand that I have a right to revoke this authorization, in writing, at any time by sending such written notification to the disclosing agency. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization.
- **Redisclosure**: I understand that medical/educational information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it will no longer be protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected under the Family Educational Rights and Privacy Act (FERPA).

The information to be exchanged includes psychiatric, medical, psychological, educational, drug/alcohol, and social information.

Any and all information with regard to the above records may be released except as specifically provided here:

_____ _____

Signature of Client/Client Representative Relationship to Client

_____ _____/_____/_____

Print Name Date

HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of your symptoms, examinations, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the medical health care provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirement of state law.

Your Mental Health and/or Medical Record Serves as:

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third-party payer can verify that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Spectrum Services:

We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the restriction request. You should address your restriction in writing to the Privacy Officer by asking for name of the Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.

- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain other activities for the past six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment, and Health Operations
Spectrum Services will use your PHI, with your consent, in the following circumstances:

- Treatment: Information obtained by a nurse, physician, psychologist/counselor, dentist, or another member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.
- Disclosure to others outside of the agency: If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except to report a serious threat to the health or safety of a child and/or vulnerable adult.
- For payment, if applicable: We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.
- For health care operations: Members of the mental health staff or members of the quality improvement team may use the information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.
- We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse/neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners and organ donation, research, or workers' compensation. Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

For More Information or to Report a Problem
If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the designated Privacy Officer. If you are concerned that your privacy rights have been violated or you disagree with a decision we have made about access to your health information, you may contact the Privacy Officer. We respect your right to privacy of your health information. There will be no retaliation in any way for filing a complaint with the Privacy Officer of our agency or the U.S. Department of Health and Human Services.

HIPAA Privacy Authorization for
Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time. You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read, and understand Spectrum Services. HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name: _____ _____ _____

Last First MI

Address:

_____

Street City State Zip

Date of Birth: _____

Signature: _____

Date: _____

For office use only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason:

Clinician Signature

HIPAA EMAIL CONSENT

Very important. Please read!

- HIPAA stands for the Health Insurance Portability and Accountability Act. HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Most popular email services (e.g., Gmail, Hotmail and Yahoo) do not utilize encrypted email.
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA, the federal government provided guidance on email and HIPAA. The information is available on the U.S. Department of Health and Human Services website at https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providersto-use-email-to-discuss-health-issues-with-patients/index.html.
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

UNENCRYPTED EMAIL

Please check one.

_____ I understand the risks of unencrypted email and do hereby give permission to Spectrum Services to send me personal health information via unencrypted email.

_____ I do not wish to receive personal health information via email.

_____ _____

Signature (parent or guardian if patient is a minor) Date

_____ _____

Patient name (please print) Email