Dulles Psychological Services. LLC
P: 703-493-0891 F: 703-552-1948

Informed Consent
Client-Clinician Service Agreement

Welcome to Dulles Psychological Services, LLC. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Consent for Psychological Testing

I, _____, agree to undergo psychological testing administered by DULLES PSYCHOLOGICAL SERVICES, LLC and I understand that DULLES PSYCHOLOGICAL SERVICES, LLC has assigned _____, a psychologist/a psychology trainee supervised by_____ (if the tester is a trainee) to conduct the testing and to write the testing report.

OR

I, as __legal guardian, ___parent, ___conservator with the understanding that I have the legal authority to grant consent for such psychological testing service on behalf of _____ (from hereon, referred to as "testing subject"), agree to have him/her to undergo psychological testing and I understand that DULLES PSYCHOLOGICAL SERVICES, LLC has assigned _____, a psychologist/psychology trainee supervised by _____ (if the tester is a trainee) to conduct the testing and to write the testing report.

I have read, understood and agreed to the following statement as the conditions under which I have given this consent. I also understand that with written notice, I can revoke this consent at any time.

I understand that the testing process involves the completion of a variety of psychological assessment instruments and personal interviews. The total time of the evaluation may vary and will depend upon the questions that the testing participant, the referral source, or I might have. I understand that I (or the testing participant) may experience emotional distress because of the personal nature of some of the information solicited by the testing process. I (or the testing participant) may interrupt or discontinue this testing process at any time.

After the testing process is completed, a report based on the results of the testing and information provided by me or the testing subject and others will be written. Unless I indicate otherwise in writing to the psychologist or psychology trainee who administered the testing, this report will be given to the person or agency who referred me or the testing subject for this service and a copy of this report will be kept in the testing subject's treatment record at DULLES PSYCHOLOGICAL SERVICES, LLC. An appointment with my (my child's)

psychologist/psychology associate and the person who did the testing will be scheduled to discuss the results of the psychological testing.

LIMITS OF CONFIDENTIALITY

Like all treatment records, reports and results of psychological testing are confidential and can be released only with a written consent authorizing such release. However, I understand if I or the testing subject discloses information related to suspected threats of physical harm of self or others, occurrence of child, elder, or dependent adult abuse, or if commanded by court order, DULLES PSYCHOLOGICAL SERVICES, LLC will be required to disclose such information to appropriate authorities or parties mandated by law.

PROFESSIONAL FEES

The standard fee for a testing intake ranges from $175.00 to $225.00 and testing administration sessions are $135.00 to $160.00 per hour. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash. Any checks returned to our office are subject to an additional fee of up to $25.00 to cover the bank fee that we incur. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment.

In addition to intake and administration fees, it is our practice to charge this amount on a prorated basis (the psychologist/psychology associate will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request. If you anticipate becoming involved in a court case, we recommend that you discuss this fully with your psychologist/psychology associate before you waive your right to confidentiality. If your case requires the psychologist/psychology associate's participation, you will be expected to pay for the professional time required even if another party compels them to testify.

INSURANCE

In order for us to complete the psychological evaluation, it is important to evaluate what resources you have available to pay for your (or your child's) assessment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment and psychological testing. With your permission, our billing service will assist you to the extent of filing claims but you are responsible for knowing your coverage and for letting us know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services.

You should also be aware that most insurance companies require you to authorize the practice to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems). Sometimes the clinician has to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this

Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover testing fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for testing sessions with the practice until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before we complete the assessment. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above, unless prohibited by our provider contract.

If we are not a participating provider for your insurance plan, the psychologist/psychology associate will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

CONSENT TO PSYCHOLOGICAL TESTING
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____
Signature of Client or Personal Representative

_____
Printed Name of Client or Personal Representative

Date _____

Description of Personal Representative's Authority:_____

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