9835 E. Bell Rd., Ste. 140
Scottsdale, AZ 85260
602·957·7600
www.BeljanPsych.com

CREDIT CARD AUTHORIZATION FORM

The purchaser _____, wishes to enroll _____ at Beljan Psychological Services, LLC for the following services:

Please indicate which charges will be accepted:

- ☐ Motor Cognition^2 Program; **$80.00 per hour**
- ☐ Lindamood-Bell Reading Program; **$80.00 per hour**
- ☐ Academic tutoring; **$50.00 per hour**

As part of the enrollment/administrative fees for the Motor Cognition^2 and Lindamood-Bell programs, the purchaser authorizes Beljan Psychological Services, LLC to charge the purchaser's credit card a one-time fee of $**400.00**. _____ (initials)

In addition, the purchaser should be aware that if they fail to cancel a scheduled appointment at least 24 hours in advance, a no-show fee equal to the price of the session will be charged. _____ (initials)

Please complete all fields.

Credit Card Information
Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐ Other:
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Zip Code (from credit card billing address):

Purchaser Signature: _____ Date: _____

Administration Signature: _____ Date: _____

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CLIENT INTAKE FORM

Client's Name: _____ Date of Birth: _____ Age: _____
Home Address: _____
City: _____ State: _____ Zip: _____

Mother's Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Method of Contact:
Phone: _____ Email: _____

Father's Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Method of Contact:
Phone: _____ Email: _____

Referral Source: _____
Reason for Referral: _____

Diagnoses: _____
Client has had prior testing? Yes No
If yes, when & by whom? _____
In cases of divorce, parents have:
Joint Custody (need both signatures) Sole Custody (need documentation)

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CLIENT SERVICES AGREEMENT

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 protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about procedures at that time. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims under your policy; or if you have not satisfied any financial obligations you have incurred.

SERVICES AND FEES _____ (initials)

Our practice offers brain based cognitive exercises, reading remediation, and other educational support services. Our fees are:

- Motor Cognition^2 Program; **$80.00 per hour**
- Lindamood-Bell Reading Program; **$80.00 per hour**
- Academic tutoring; **$50.00 per hour**

As part of the enrollment/administrative fees for the Motor Cognition^2 and Lindamood-Bell programs, the purchaser agrees to pay Beljan Psychological Services, LLC a one-time fee of $**400.00**.

A 'no-show' is defined as failure to cancel a scheduled appointment 24 hours prior to the appointment or completely failing to show for a scheduled appointment. Our no-show fee is equal to the price of the session. By signing this Agreement, you agree to comply with this policy.

CONTACTING OUR OFFICE

Our office hours are 9 AM to 5 PM, Monday thru Friday. If no one answers, leave a message with detailed information and we will return your call by the next business day. Alternatively you may contact your facilitator directly at the contact number provided by him/her. If you are difficult to reach, please

include in your message the most favorable times we can contact you. The clinical staff also finds it efficient to set phone appointments to insure timely contact. If you are unable to reach us and feel that you cannot wait, you can call the **Maricopa Crisis Line @ 1-800-631-1314** or contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

LIMITS ON CONFIDENTIALITY _____ (initials)

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require you provide written advance consent. Your signature on this agreement provides consent for those activities, as follows:

- We may find it helpful to consult other medical and mental health professionals about a case. During a consultation we do not reveal the identity of the patient. The other professionals are also legally bound to keep the patient information confidential. If you do not object, we will not tell you about these consultations unless we feel it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that we practice with other mental health and allied health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member who has prior written authorization. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a patient threatens to harm himself\herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- Situations occur where we are permitted or required to disclose information without either your consent or authorization:

    - If you are involved in a court proceeding and request is made for information concerning the professional services we provided you, such information is protected by the psychologist-patient privilege law. We cannot provide any information without you or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

    - If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

    - If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

    - If a patient files a worker's compensation claim, and we are providing services related to

that claim, we must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment.
These situations may include:

- If we have reason to believe that a minor who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires us to file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.

- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires us to file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, we may be required to provide additional information.

- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim including themselves, and we believe that the patient has the intent and ability to carry out such threat, we must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit disclosure to only what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to us confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. This accessibility does not extend to testing protocols, because of test security issues. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, we are allowed to charge a copying, postage, and administrative fee.

PATIENT RIGHTS
The Health Insurance Portability and Accountability Act (HIPAA) provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS
Patients under 18 years of age (minors) who are not emancipated from their parents should be aware that the law may allow parents to examine their treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else; in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS _____ (initials)
You will be expected to pay for each session at the time it is billed, unless we agree otherwise. Payment schedules for other professional services will be discussed when they are requested. If your account has not been paid for more than sixty (60) days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, all costs will be included in the claim and be the responsibility of the patient.

INSURANCE REIMBURSEMENT _____ (initials)
This is a fee for service practice. We do not accept insurance. If you wish to submit a claim to your insurance company, we will provide you with a diagnosis page and CPT codes. All insurance companies claim to keep such information confidential; we have no control over the use of the information once it has been submitted to the insurance company. By signing this Agreement, you agree that we can provide requested information to your carrier.

PREFERRED & ACCEPTABLE CONTACT
Please specify your preferred form of contact:

Telephone: _____ Type: _____
Email: _____
Mail: _____

APPROVAL GIVEN

By signing this Agreement you give us the permission to treat you or your child in accordance with the information stated in this document. This treatment includes but is not limited to brain based cognitive exercises, reading remediation, and other treatments previously discussed and agreed upon with the patient and/or guardian.

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.

_____ _____

Patient's Name Guardian's Name if patient is a minor

_____ _____

Patient or Guardian's Signature Date

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I have received a copy of:

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

(This information may be obtained online at www.BeljanPsych.com)

_____ _____
Patient's Name Guardian's Name if patient is a minor

_____ _____
Patient or Guardian's Signature Date