DR. JEFF DRAYER

Thank you for contacting the practice. Prior to our initial meeting, several documents will need to be completed. The required documents can all be downloaded at: www.drjeffdrayer.com or you can request a paper copy be mailed to you. These documents include:

- Child Development Questionnaire
- Agreement and Consent for Psychological Services & Evaluation
- Financial Agreement
- Privacy Notification and Consent to Discourse Information

In addition, information is provided to you regarding the management of confidential health information. Please take the time to review and complete the enclosed paperwork. I strongly encourage you to forward the child questionnaire before our first appointment in order for this information to be reviewed ahead of time. You may bring the remaining documentation with you to the initial appointment. Given the sensitive information discussed at the first appointment, your child need not attend. However, if your child is older (generally 16 years+) and would like to participate, this is encouraged.

The office is located at:
555 Washington Street
Suite #5 (Second Floor)
Wellesley, MA 02482

Parking is on-street or in a municipal lot across the street. Parking spaces are metered. **Please note that the office is on the second floor and the building has no elevator. If you have mobility concerns, please contact the office ahead of time.**

Please feel free to contact the office at (781) 237-1174 or you can email Dr. Drayer at jdrayer@drjeffdrayer.com. Information is also available at www.drjeffdrayer.com.

I look forward to working with you and your family.

Jeffrey Drayer, Ph.D.
Licensed Psychologist
Pediatric Neuropsychologist

DEMOGRAPHIC INFORMATION

Patient Name: _____

Parents/Guardian Name: _____

Date of Birth: _____

Address: _____

Town/Zipcode: _____

Home Phone: _____

Cell Phone: _____

CONSENT AND AGREEMENT TO PSYCHOLOGICAL SERVICES & EVALUATION

Child's Name: _____ Date of Birth: _____

I, _____, agree to allow Jeffrey Drayer, Ph.D. to perform an evaluation, which may include neuropsychological, psychological, and educational testing/educational services as well as and collaboration and consultation with other members of the clinical team for the purposes of coordinating care. I grant authorization for the following individuals or entities:

☐ Consultation with school personnel

☐ _____ Pediatrician

☐ _____ _____ (title)

☐ _____ _____ (title)

☐ _____ _____ (title)

_____ Date: _____
Signature of Parent or Guardian (if child is under 18 years old)

_____ Date: _____
Patient's Signature if over the age of 18-years

DIVORCE AGREEMENT

To be completed in the case of in which parents are divorced, separated, never married, or care is being provided through foster care for children under the age of 18-years old. Both parents' signatures are required in the case of joint legal custody of the potential child receiving services. Custody situations can be discussed at the initial consultation.

I consent to services with with Dr. Jeff Drayer for evaluation and/or treatment services. These services are provided with the best interest of my child. I understand that Dr. Jeff Drayer or the services rendered will not serve in the role as a court investigator, Guardian ad Litem (GAL), mediator, or forensic evaluator. I understand that Dr. Jeff Drayer will most likely not be able or willing to make recommendations or voice opinions that relate to questions such as custody, visitation, etc.

In cases where both parents have joint custody, written consent is required by both parents to begin and continue services. Such consent is required before bringing my child for services. I also understand that if one legal custodian decides to revoke consent at any time services may be terminated and psychological harm to the child could result.

In regards to the release of information to either parent/guardian with joint custody, both parents/guardians agree that information will not be released to either parent or a third party without the explicit consent of both parents/guardians. I also agree that I will not subpoena Dr. Jeff Drayer or any records as a condition of consent to treatment.

I confirm that I have read and agree to the above terms and guidelines for treatment outlined above.

Child's Name: _____

Parent Signature: _____ Date: _____

Other Parent Signature: _____ Date: _____

Please provide the name, address, and telephone number below of the second parent/guardian if not already on record.

Address:
Street: _____

Town/State/Zip code: _____

Telephone: _____

FINANCIAL POLICIES AND STATEMENT

A neuropsychological evaluation for children, adolescents, and often for young adults consists of both clinical and educational components. Clinical components of a neuropsychological evaluation focus on many areas of neurologic functioning such as: cognition, memory, language, social pragmatics, attention, executive functioning, motor skills, and emotional functioning. Educational aspects of an evaluation can include the following: assessment of academic functioning using standardized testing, review of educational records, consultation with teachers and other educational members of the patient's team, and development and written documentation of educational services and recommendations.

Health insurance companies may provide coverage for the clinical components of an evaluation. However, health insurers based on their policies do not cover the educational component of an evaluation. Therefore, based on each patient's individual presentation, the clinical aspects of the evaluation may be covered by insurance, but the educational portion of the evaluation is not covered by insurance and is your responsibility.

If Dr. Drayer is a provider of your insurance, he will accept payment from the health insurer as payment in full for covered services rendered. However, in some cases health insurers decide that a portion or all of the evaluation is not medically necessary. In these instances, you will be responsible for services that are found to not be "medically necessary" by your health plan.

If you decide to proceed with services for your child prior to payment being made in full, I ask that you guarantee any subsequent costs for services with a credit card (please see attached).

I understand that insurance coverage and the educational components of a neuropsychological evaluation can be confusing. Insurance coverage and financial obligations are specifically reviewed during the initial consultation and a financial letter (including itemized costs) will be provided to you shortly after the initial consultation (typically within a business week).

Your signature below indicates that you understand and consent to these policies.

Parent Signature: _____ Date: _____

Parent Signature: _____

Credit Card Authorization

I understand and agree that the services which I am initiating at the present time may entail costs not covered by my health insurance plan, and that these costs will be my responsibility upon completion of the service.

The Practice asks that a credit card be kept on file in situations where there is a remaining balance on your account. The practice will *not charge* your credit card until you have received notification of the outstanding balance and have been provided with thirty days to make payment through alternative forms. Your credit card information will be kept secure within your or your child's record. If your credit card is charged, it will be charged through the Practice's secure bookkeeping services.

I authorize charge to the credit card below in the amount of the services provided at my request, unless payment is made in another form.

Credit Card Type (The office does not accept American Express: _____

Credit Card #: _____

Security Code (on back of Card): _____

Expiration Date: _____

Name on Card: _____

Signature: _____ Date: _____

Insurance Information

Name of Insurance Company: _____

Name of Subscriber: _____

Policy Number: _____

Location of Plan: _____
(state of origin)

I give Dr. Jeff Drayer's office permission to release any information obtained during examination or treatment of this patient that is necessary to support any insurance claim on this account and secure timely payments due to the assignee or myself. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the psychologist above. A photocopy of this assignment is to be considered as good as the original.

Patient's Name: _____

Parent/Guardian Signature: _____ Date: _____

PRIVACY NOTIFICATION

For the purposes of this privacy notification "the Practice" will refer to Dr. Jeff Drayer and "you/your" will refer to your child or you as the patient (if over the age of 18).

The Practice is committed to keeping your personal health information (PHI) private. In addition, it is a requirement by law to keep personal health information confidential and private. These laws are quite detailed and can be complicated. Nonetheless, it is important and necessary that you receive this information. Below is a condensed version of a full, legally required notice of privacy practices. The full version of your privacy rights can be downloaded from the Practice's website at www.drjeffdrayer.com or you may request a printed copy at any time. You may also visit the United States Health and Human Services website for more information on personal health privacy (www.hhs.gov).

How your personal health information will be disclosed and protected:
The primary use of your personal health information is to provide you with treatment. In addition, PHI can be used to arrange for payment of services, and for other business-related activities that are called in the law, "health care operations". Once you have read and reviewed your privacy rights, you are asked to sign a consent providing permission for the Practice to use and share your PHI in these ways. If you do not consent and sign this form, services and treatment cannot by provided. If you request that your child's information be used, sent, or shared for other purposes, this can be discussed and you will be asked to sign a separate "consent for release of information" form to allow this disclosure.

Using PHI for health care operations (e.g., for the purpose of business or administrative functions):
Examples of health care operations include accountants and bookkeepers who access records. These professionals will be required to sign contracts with the Practice mandating that they keep any information that access completely confidential.

Disclose of PHI without your consent:
There are times when the laws require the Practice to use or share your information. Instances may include:

- When there is a serious threat to your/your child's or another's health or safety or the public. Information will only be shared with persons who are able in the role to health or prevent or reduce safety risk.
- When the Practice is mandated to report child abuse or neglect or elder abuse or neglect.
- In the incidents where it is required by lawsuits and other legal or court proceedings.
- If a law enforcement official requires it.
- For worker's compensation and similar benefit programs.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the HIPAA Privacy Rule and the

Commonwealth of Massachusetts confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Your rights regarding your health information:

- You are entitled to ask the practice to communicate with you in a particular way or at a certain place that is more private for you. For example, you may request to be contacted at your home phone number rather than your cell phone or at work.
- You can request for the Practice to limit what is communicated in terms of your care or payments for your child such as family members and friends.
- You have the right to look at the health information that is obtained regarding you/your child such as medical, clinical, and billing records. You are also entitled to get a copy of these records.
- If you believe that the information in your or your child's records is incorrect or missing important information, you can ask to make additions to your records. You have to make this request in writing. You are also need to inform the Practice of the reasons you want to make the changes.
- You have the right to restrict disclosures when you have paid for your care "out of pocket" (i.e., you have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for our services.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care that is provide to you in any way. You also have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I would be happy to discuss these situations with you now or as they arise.
- You have the right to a copy of this notice. If you have any questions regarding this notice or the health information policy policies, please contact the office directly at (781) 237-1174.

You have a right to be notified if there is a breach of your unsecured PHI. You a right to be notified if: (a) there is a breach (e.g., a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not bee encrypted to government standards, or (c) the practice's risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Other important facts about breaches in PHI:

- When the Practice becomes aware of or suspects a security breach the Practice will conduct a Risk Assessment. The Practice will keep a written record of that Risk Assessment.

- Unless the Practice determines that there is a low probability that PHI has been compromised, the practice will give notice of the breach within 60 days of discovery.
- The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
- After any breach, particularly one that requires notice, the Practice will reassess its privacy and security practices to determine what changes should be made to prevent the reoccurrence of such breaches.

The effective date of this notice and privacy policy is September 23, 2003.

Electronic communication: at times, you may wish to communicate with the office by email. Please note that this is not necessarily a secure means of communication. The Practice uses an encrypted email system (business associate) with an agreement of security. Although this system is quite secure, no system can be 100% secure.

The Practice requires that you sign this notification that you have read and agreed to your privacy rights and personal health information disclosure and protection.

_____ _____

Signature of Parent/Guardian or Client if over 18-years Date

_____

Print Name