# 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
- Informed Consent during COVID-19
- Informed Consent for Telepsychology
- 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. I have two office locations in Wellesley and Easton. Before the day of your appointment, please confirm the location.

**Wellesley Office**
555 Washington Street
Suite #5 (Second Floor)
Wellesley, MA 02482

**Easton Office**
559 Foundry Street
South Easton, MA 02375

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 Wellesley office at (781) 237-1174, the Easton office at (508) 297-0291, 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: _____

Email Address: _____


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**INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS**

This document contains important information about our mutual decision to participate in in-person services in light of the COVID-19 public health crisis. Please read this carefully and contact our office if you have any questions.

**Decision to Meet Face-to-Face**

We agreed to meet in person for some or all future services. You understand that by coming to the office you are assuming the risk of exposure to the coronavirus (or other public health risks). This risk may increase if you travel by public transportation, cab, or ride sharing services.

Your clinician will make every effort to maintain physical distancing during your time in the office. However, the administration of certain tests requires that the clinician sit at a table (within six feet) of a child. For families requesting services at the Wellesley location, in accord with requirements set forth by the Town of Wellesley we require all visitors to this location wear masks (including children during testing). Staff must also wear masks. Masks are also strongly encouraged in the Easton location for children, family members, and staff.

In addition, during in-office testing, the clinician may decide to administer some measures remotely. This may entail interacting with your child from another room using a monitor and intercom. Decisions about inter-room administration will be made on the basis of a child's developmental and emotional needs, and will be discussed with you ahead of your visit.

**Your Responsibility to Minimize your Exposure**

To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure, sickness and possible death.

We understand that children vary in their developmental preparedness for participation in pre-cautionary measures. we are committed to working with every child and family in the safest manner possible; please speak with your clinician before your appointment with regard to any concerns you have regarding masks, physical distancing, etc.

Please initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you and your child are symptom free _____
- You will take your and your child's temperature before coming to each appointment. If it is elevated (100 degree Fahrenheit or more), or if you have other


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symptoms of the coronavirus, you agree to cancel the appointment or proceed during telehealth. THERE ARE NO CANCELLATION FEE. _____

- You and your child will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. _____
- You will wait in your car while your child participates in testing. Should your child require you close at hand during testing, please inform us and alternate arrangements will be made. _____
- You and your child will wash your hands or use alcohol-based sanitizer when you enter the building. _____
- You and your child will adhere to the safe distancing precautions with have set up in the waiting room and testing room. For example, you won't move chairs or sit where we have signs asking you not to sit. _____
- You and your child will wear a mask in all areas of the office. _____
- There will be no physical contact (e.g., no shaking hands) with staff. _____
- You and your child will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately let our staff know. _____
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let our staff know. _____
- If a resident of your hone test positive for the infection, you will immediately let our staff know. _____

We may change the above precautions if additional local, state or federal orders or guidelines are published.

**Our Commitment to Minimize Exposure**

Our practice has taken steps to reduce the risk of spreading the coronavirus within the office. Please let us know if you have questions about these efforts. If anyone on our staff tests positive for the coronavirus, we will notify you so that you can take appropriate precautions.

**Your Confidentiality in the Case of Infection**

If you or your child have tested positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and well not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that we may do so without an additional signed release.

**Informed Consent**

This agreement supplements the general informed consent/business agreements for our practice.


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Your signature below shows that you agree to these terms and conditions.

_____ _____

Parent/Guardian Signature (or patient if over the age of 18) Date


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## INFORMED CONSENT FOR TELEPSYCHOLOGY

Some or all of your child's evaluation may take place via telepsychology. Use of telepsychology will vary from one evaluation to another, based on the needs of the child, the purpose of the evaluation, and technological variables. Your clinician will discuss the use of telepsychology (including technical and environmental requirements) with you prior to the beginning of your child's evaluation. The Informed Consent for Telepsychology contains important information focusing on doing telepsychology using the phone or the Internet.

### Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy ort assessment-based services remotely using telecommunication technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychology and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of our office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end, we will take reasonable steps to ensure your privacy, but it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in telepsychology only while in a room or an area where other people are not present and cannot overhear the conversation.

- Issues related to technology. there are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychological services. However, some clinicians believe that something is lost by not being in the same room. For example, there is debate about a clinician's ability to fully understand non-verbal information when working remotely.

- Testing. Most psychological, neuropsychology, and educational tests have been developed and standardized for in-person use. Research on remote application is ongoing, but at the present varies form one instrument to another. Your child's clinician will make every effort to use remote testing in the most valid and reliable manner possible, however, in some cases this represents a departure from test standardization and may impact conclusions derived from those tests as well as the

use of these tests in educational or legal settings. You should discuss the specifics of your child's battery with your clinician.

**Confidentiality**

We have a legal and ethical responsibility to make our best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private and will not record any telepsychology sessions without previous written consent; however, there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology). The extent of confidentiality and the exceptions to confidentiality that we outlined in our Informed Consent still apply in telepsychology. Please let us know if you have any questions about exceptions to confidentiality.

Please note: test materials are copywritten by test publishers, and it is expressly forbidden for you or your child to save, print, record, photograph, or otherwise preserve materials used in tele-assessment.

**Informed Consent**

This agreement is intended as a supplement to the general Informed Consent that we agreed to at the outset for our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____

Signature of Parent or Guardian (or patient if over 18) Date


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CONSENT AND AGREEMENT TO PSYCHOLOGICAL SERVICES & EVALUATION

Child's Name: _____ Date of Birth: _____

I, _____, agree to allow the practice (Dr. Jeff Drayer, LLC) 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


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# 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 the practice (Dr. Jeff Drayer, LLC) for evaluation and/or treatment services. These services are provided with the best interest of my child. I understand that the practice 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 the practice 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 the practice 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: _____


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# 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 the practice (Dr. Jeff Drayer, LLC) is a provider of your insurance, we 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: _____


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## 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 (Visa, MC, Discovery, or AE): _____

Credit Card #: _____

Security Code (on back of Card): _____

Expiration Date: _____

Name on Card: _____

Signature: _____ Date: _____


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Insurance Information

Name of Insurance Company: _____

Name of Subscriber: _____

Policy Number: _____

Location of Plan: _____
(state of origin)

I give the practice (Dr. Jeff Drayer, LLC) 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: _____


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# 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.


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- 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


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