

Neuropsychology & Concussion Management Associates, LLC (NCMA)
Services Agreement and Consent Form for Neuropsychological Wellness Services

This document contains information about our professional services and policies. A Health Insurance Portability and Accountability Act (HIPAA) Notice is available to you on our website, in our waiting room and can be mailed to you upon request. To provide services to you, we require your signature acknowledging that we have provided you with access to this information and that you have given your informed consent to the services and the practices described in this document. When you sign this document, it will represent an agreement between us. You may cancel this agreement in writing at any time. That cancellation will be binding except 1) to the extent that we have already acted in reliance on it and 2) if you have not satisfied financial obligations already incurred.

Fees/Payment Arrangements

A fee of \$495.00 is due at the time of service and cannot be submitted to health insurance for reimbursement.

Communications with us

When we are not available to answer the phone, you may leave a voice mail message, which is secure and accessed only by NCMA staff. Calls are generally returned within 24 hours or on Monday in the case of a Friday message. Because of the nature of the services we provide, we do not provide emergency coverage. If you have an emergency, you should call your physician or go to your nearest emergency room, as appropriate. You can go to our website and use Contact Us. This is seen by Dr. Bryant and administrative staff. We use encrypted Outlook email.

Wellness Exam

A wellness exam involves brief interview with a neuropsychologist, brief testing to screen for cognitive health and any depression or anxiety that could contribute to cognitive challenges. Testing takes about an hour and is non-invasive. It involves tests of attention, processing speed, memory, language, visual spatial skills, reasoning, organization, and problem solving. Results are provided and reviewed same day. Recommendations are made for how frequently to rescreen, usually every 3 to 5 years.

Records

Your record with us will include the history questionnaire that you complete for the first wellness exam (and any notes taken during your conversation with your neuropsychologist about pertinent history) and history update forms that you complete for subsequent exams along with the test data obtained and any suggestions or plans that you and your neuropsychologist make regarding improving or maintaining your cognitive wellness going forward. You may examine and/or receive a copy of your record if you wish, except for copyrighted test material that is meant to be kept confidential to avoid rendering the tests useless. In Maine, per Chapter 353 Section 1.22 MRSA § 1725, we cannot release the raw test data to anyone other than an appropriately trained professional, such as another neuropsychologist. We are happy to do this at your direction (with authorization). Data that we collect about you is stored electronically in house and physically secured and/or password protected and is backed up in encrypted form.

Standard Limits on Confidentiality

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we only release information about you to others if you sign a written Authorization for Release of Information form that meets certain legal requirements imposed by HIPAA and/or state law and Psychologist' Ethics guidelines, or in some cases, if you provide oral authorization. However, in the following situations, no authorization is required:

For purposes of clinical consultation and professional development, we consult with other neuropsychologists and other health professionals as relevant. These individuals are all bound by

the same laws, though ethical standards vary from profession to profession. Unless authorized to do otherwise (or unless the circumstance falls within another condition discussed within this Agreement), we exclude information that could easily identify the specific patient. We disclose only the information necessary to the consultation question.

If you are, or may become, involved in a court proceeding and a request is made for information concerning your personal health information, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your written authorization, the written authorization of your legal representative or a court order from the judge.

If a government agency is requesting personal health information for health oversight or security activities, we may be required to provide it to them. (In our practice, this has never been requested without a signed release by the patient)

If you were to file a lawsuit or a complaint against NCMA, Dr. Bryant, or any of the staff employed by or contracted to provide services for NCMA, we may disclose relevant personal information about that patient to respond to the complaint or lawsuit. (This has never happened in NCMA or Dr. Bryant's practice)

There are some circumstances under which we are legally obligated to take actions to attempt to protect people from harm, and in carrying out those actions, some of your personal information could be disclosed. These situations are very unusual in our experience. If we know or have reasonable cause to suspect that a child under the age of 18 has been or is likely to be abused or neglected or that a vulnerable adult has been abused, neglected, or exploited and is incapacitated or dependent, we are required by law to file a report to the appropriate government agency. If we determine that you pose a direct threat of imminent harm to the health and safety of any individual including yourself, we may be required to disclose information to take protective action(s).

Your signature below indicates that you have read this agreement and agree to the terms, have been given information necessary to provide informed consent to neuropsychological wellness services from NCMA and are consenting to those services and serves as an acknowledgement that the HIPAA notice has been made available to you.

Signature _____ **Date** _____

Printed Name _____