info@mailppa.com
www.SouthFloridaTherapists.com
(305) 936-1002 (305) 936-1022
South Florida & New York Tri-State Area
Telepsychology Across PSYPACT States

Dear Parent/Caregiver:

Welcome to our practice. In preparation for your first appointment, we have attached several forms to be filled out and signed by each parent. This will help us gather information regarding your child and family prior to beginning treatment. It is important that all of these forms are reviewed and completed before your first appointment.

Forms to complete:

- Forensic Family History Form
- Legal & Ethical Limitations in Individual Treatment **or** Legal & Ethical Limitations in Reunification Treatment (sign if applicable)
- Forensic/Legal Services Policies & Fees
    - Credit Card Payment Consent Form*
- HIPAA Notice of Privacy & Health Information Practices
- Telehealth Policies & Procedures

**If parents are sharing payment of services, please fill out one form for each parent.*

Who is Responsible for Payment?

If you have a court document outlining financial responsibility for mental health treatment, please share with our office when forwarding completed forms. Otherwise, in signing the *Forensic/Legal Services Policies & Fees* form, you are agreeing to pay for the treatment your therapist is recommending, and that may include your child(ren)'s other parent in some sessions. If expert witness or consulting services are requested by a parent and/or an attorney, payment is required directly from that individual. If you have any questions about who is responsible for payment, please consult with your legal counsel and/or parenting agreement (if applicable). Please note that our office will not provide services if payment information is not submitted and agreed upon by all parties.

We encourage you to complete these forms prior to your first appointment and forward to info@mailppa.com or fax to (305) 936-1022, along with additional paperwork that may outline legal parameters of custody, payment responsibility, visitations, and/or previously documented incidents.

If you should have any questions, do not hesitate to contact us.

Warmest Regards,

Pediatric Psychology Associates

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FORENSIC FAMILY HISTORY FORM

Name of Parent/Caregiver Completing Form:_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

(If more than 4 children, please write on back of page-child's name, age, birthdate)

Do your child(ren) have a cellular phone(s)? If so, please list child's name and number(s)?

_____

_____

What are the concerns or difficulties that cause you to seek professional help at this time?

_____

_____

_____

PARENT INFORMATION

Parent 1 Name_____Age_____Birthdate_____

Email:_____Occupation:_____Education_____

Cellular_____Alternative Phone:_____

Home Address_____

City_____State_____Zip Code_____

Attorney's name (if applicable) _____

Parent 2 Name_____Age_____Birthdate_____

Email:_____Occupation:_____Education_____

Cellular_____Alternative Phone:_____

Home Address (if different than Parent 1 Address)_____

City_____State_____Zip Code_____

Attorney's name (if applicable) _____

Date of: Marriage_____Separation_____Divorce_____Mark if never married ☐

Are there other persons living at home(s)? Yes☐ No☐ If yes, who?_____

_____

If applicable, what is the child(ren)'s relationship with parent's significant other or stepparent?

_____

Is there a parenting plan in place at this time? Yes☐ No☐ (If yes, please provide a copy)

Has a Guardian ad Litem been appointed: Yes☐ No☐ If so, Name _____

Contact information _____

Child(ren) live with:☐ Biological ☐ Adoptive parents ☐ Other _____

If parents are living apart (separated/divorced) is the other parent aware that you are seeking psychological services? * Yes☐ No☐ **A consent form must be signed by the other parent if parents are divorced or living apart AND if the children will be part of our psychological sessions.*

Describe living/time-sharing arrangements: _____

_____

_____

How often do you have contact with the children when they are not with you? _____

_____

Describe the contact (visits, supervised/unsupervised, phone, etc.): _____

_____

_____

Describe your relationship with the other parent. Excellent☐ Good☐ Fair☐ Poor☐ The worst☐

What effect do you think this relationship has on the child(ren)?

A great deal☐ Some☐ A little☐ None at all☐ Not sure☐

How often do you have contact with the other parent? _____

How do you communicate (text, Talking Parents, Our Family Wizard, email)?_____

_____

Describe the problem(s) that have occurred between you and the other parent:

_____

_____

_____

Are you fearful of the other party for any reason? Yes☐ No☐ If yes, explain:_____

_____

Has the other party ever threatened to hurt you in any way? Yes☐ No☐ If yes, explain: _____

_____

Has the other party ever hit you or used any other type of physical force towards you? Yes☐ No☐

If yes, explain: _____

Has the other party emotionally, sexually or emotionally abused you? Yes☐ No☐ If yes, explain:

_____

Have you ever called the police, requested a protection for abuse order, or sought help for yourself as a result of abuse by the other party? Yes ☐ No ☐ If yes, explain:_____

_____

Has the other party ever threatened to deny you access to your child(ren)? Yes ☐ No ☐

If yes, explain:_____

Are there concerns about the children's emotional or physical safety? Yes ☐ No ☐ If yes, explain:

_____

_____

Have you or the other party abused alcohol or drugs? Yes☐ No☐ If yes, explain: _____

_____

Check the description of present alcohol use (including beer, wine, liquor)

Daily☐ Once or twice a week☐ Once or twice a month☐ None☐

Check all that apply current or prior drug use or abuse: Current☐ Past☐ Neither☐

If yes, please list type used:_____

Please list use of prescription and/or non-prescription drugs:_____

_____

Have you ever been arrested for an alcohol/drug related crime? Yes☐ No☐ If yes, please explain:

_____

_____

Have you ever undergone treatment for substance or alcohol use/abuse? Yes☐ No☐

If yes, please explain: _____

_____

Please rate the effectiveness of this treatment: Very effective ☐ Helpful ☐ Waste of time ☐

Do you have concerns regarding the other parent's use of alcohol or other substances? If yes, please explain:_____

_____

Are you now or have you ever been on probation or parole? Yes☐ No☐ If yes, please explain:

_____

_____

Have you ever had a restraining order filed against you? Yes☐ No☐ If yes, please explain:

_____

_____

Is there a restraining order in effect right now that you are involved in? Yes☐ No☐

Have you or the other parent participated in domestic violence classes, batterer's intervention or anger management? Yes No If so, when? _____

If yes, please rate the effectiveness of these classes in eliminating abusive behavior:
☐ Very effective. ☐ Helpful. ☐ Waste of time

Have there ever been charges filed against you for physical assault, battery, domestic violence, or stalking?_____If yes, please explain: _____

_____

Do you have any concerns about your physical safety during joint meetings held with the other parent?_____If yes, please describe:_____

_____

_____

Is there anything else that would be helpful for me to know about the other parent, your child, or your situation? _____

_____

_____

BRIEF FAMILY HISTORY

Are there any health/learning/emotional issues about your child(ren) I should be made aware of?

If so, please list child's name and describe in detail:_____

_____

_____

_____

_____

What language(s) does your child(ren) speak and which is primary?_____

What language(s) are spoken in the home and which is primary?_____

Religious Affiliation:_____

Where does your child(ren) sleep in their home(s)? _____

By whom is your child(ren) usually disciplined?_____

What type of discipline is used?_____

Usually for what reason?_____

How does your child(ren) respond to discipline?_____

Do parents differ on discipline? Yes☐ No☐ If so, how?_____

_____

Please mark any areas which constitute a problem for your child(ren)-check and list name of child:

☐ Eating
☐ Sleeping
☐ Nightmares
☐ Thumb sucking
☐ Nail biting
☐ Bedwetting
☐ Wetting clothing
☐ Soiling bed
☐ Soiling clothing
☐ Getting along with friends
☐ Self-help skills (dressing, bathing, eating, etc.

List school and grade level of your child(ren):

_____

_____

_____

Has your child(ren) ever had counseling/psychotherapy, psychoeducational or psychological testing, speech, occupational or physical therapy, or seen a psychiatrist or received medication for behavior, attention or emotional problems? Yes☐ No☐ If yes, list child(ren) name, date(s), name of practice/therapist(s) for each area:_____

_____

_____

Is there any family member (sibling, parent, grandparent, cousin, etc.) who presently have or in the past have had learning, attentional, or psychological/emotional issues or were in special classes? If so, who and what kind/type?_____

In addition to the current family situation/conflict, has your child(ren) ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? Yes☐ No☐

If yes, list child's name and describe. _____

_____

_____

Please put any other comments that will help us understand your child(ren) and current family situation better. _____

_____

_____

What are your goals/expectations from treatment?_____

_____

_____

What do you think it would take to achieve your treatment goals? _____

_____

_____

_____

Please note <u>we do not confirm appointments</u>, although we typically provide courtesy appointment reminders through email and text message. Even in the event that you do not receive a courtesy reminder, you are still responsible for your appointment. Please list your email and best cellular contact number below if you would like a courtesy reminder.

Email address (*Please write clearly*):_____

Cellular number:_____

Would it be okay to contact and thank the party responsible for the referral? Yes ☐ No ☐

If so, list name and phone # or e-mail: _____

In addition to being referred by a specific agency/individual, did you received or view any promotions or social media content listed below about our practice? If so, check all that apply: ☐ Google ☐ Email ☐ Flyer ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other, please specify: _____

Signature _____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for treatment by Pediatric Psychology Associates for myself and/or my family members.

Signature_____**Relation to Patient** _____

Printed Name_____**Date**_____

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LEGAL AND ETHICAL LIMITATIONS IN INDIVIDUAL TREATMENT

1. Information provided by the minor in treatment is confidential. Therefore, the clinician cannot testify about information provided by the minor in treatment unless court ordered to do so.
2. If the clinician has reason to be concerned about the potential or possibility of previous, present, or future minor abuse or neglect, confidentiality is waived. The clinician is a mandated reporter and may need to make a report to the Department of Children and Families to investigate possible safety concerns.
3. Other than concerns about safety issues, clinician will not provide parents or guardians with detailed updates regarding specific content discussed in sessions with minor. This is meant to provide a safe space for them to feel comfortable being open and honest in sessions.
4. Information shared by either parent to the clinician is **NOT** confidential. Therefore, any information provided to the clinician by either parent or other parties involved in treatment, other than the minor, is subject to be shared with other parties with appropriate consent or court order. Communications with parents and/or guardians are not considered confidential.
5. Once the clinician has begun individual treatment, she is unable to perform any other mental health related services or interventions aside from that role.
6. The clinician must contact the minor's other parent to gather relevant background information regardless of whether they are actively participating in treatment or not. This is part of the treatment process and will incur a session fee charge.
7. The clinician needs written consent from the other parent for their minor to participate in treatment, **unless** there is documentation that notes that one parent has ultimate decision-making authority.
8. Release of treatment records **may not** be released even with both parents' consent, **if** the clinician has reason to believe this release of information could be harmful to the minor in any way, and/or without a court order to do so.
9. The clinician providing individual therapy is not able to make recommendations or changes to timesharing or speak to the other's parents' state of mental health. Moreover, the clinician does not have the authority or power to make the other parent follow agreed upon parenting plans in place at the time of treatment.
10. The clinician cannot speak to or include in treatment any outside parties such as the minor's school, other family members (i.e., stepparents, grandparents, etc.), attorneys, medical providers, etc., without the written consent of both parents.
11. The clinician cannot provide therapeutic interventions or recommendations via email. Quick updates on the minor's functioning and scheduling are the only purposes of email communications outside of scheduled sessions.

Name of Patient(s):_____ **Date:**_____

I,_____**, certify that the clinician reviewed these limitations with me and understand the above information and how it applies to my child's treatment.**

Signature:_____ **Relation to Minor**_____

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LEGAL AND ETHICAL LIMITATIONS IN REUNIFICATION TREATMENT

1. Information provided by all treatment participants is not considered confidential, as it may most likely need to be reported back to the court.
2. The clinician is a mandated reporter and may need to make a report to the Department of Children and Families to investigate possible safety concerns.
3. Other than concerns about safety issues, clinician will not provide parents or guardians with detailed updates regarding specific content discussed in sessions with minor(s). This is meant to provide a safe space for them to feel comfortable being open and honest in sessions.
4. The clinician most likely will need to meet with the child(ren), the reunifying parent, and the non-reunifying parent in separate meetings in order to address ongoing issues, conflict, or barriers to reunification success throughout the reunification process. As a result, there most likely will be weeks in which the children do not meet with the reunifying parent or only meet for part of the session in an effort to address these barriers to treatment success as they arise. This is part of the treatment process and will incur session fee charges.
5. The reunification process is one that takes time and moves at a pace appropriate for the child(ren), not according to either parents' desire for rate of treatment progress.
6. Once the clinician has begun reunification treatment, they are unable to perform any other mental health related services or interventions aside from that role.
7. The clinician providing reunification therapy is <u>not able</u> to make recommendations or changes to timesharing.
8. Both parents will sign releases of information for the clinician to speak to both parties' attorneys and any other relevant providers in the case, including but not limited to, the Guardian ad Litem, previous or current mental health professionals, and social investigators. Please note, the clinician cannot speak to or include in treatment any outside parties such as the minor's school, other family members (i.e., stepparents, grandparents, etc.), medical providers, etc., without the written consent of **both** parents.
9. The clinician cannot provide therapeutic interventions or recommendations via email. Quick updates on the minor's functioning and scheduling are the only purposes of email communications outside of scheduled sessions. Any time spent outside of sessions will also incur a fee for services as outlined in *Forensic/Legal Services Policies and Fees Sheet* (this includes emails, phone calls, review of records, etc. to parent[s]/caregivers, other family members, attorneys, outside professionals, etc.).

Name of Patient(s):_____ **Date:**_____

I, _____**, certify that the clinician reviewed these limitations with me and understand the above information and how it applies to my child's treatment.**

Signature:_____ **Relation to Minor**_____

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FORENSIC/LEGAL SERVICES POLICIES AND FEES

Forensic/Legal services include and are not limited to: Individual Psychotherapy, Family Psychotherapy, Reunification Therapy, Guardian Ad-Litem, Parent Coordination, Parent Training, Expert Witness, Social Investigations, Professional Consultation, etc. The specific services and fee will be discussed prior to the first appointment or at the first appointment. Services are billed hourly, however, may be billed in 15-minute increments for additional services. Therapy sessions will be 45 to 60 minutes depending on the recommended time and billed accordingly. Prior to the beginning of this process, determination will be made as to how payment will be made and by whom. Services include telehealth and in-office meetings, as well as phone calls with parent(s) and/or child(ren), as well as other professionals related to the case. Additional treatment services that will be billed include consultations, video conferences, telephone contact and email contact with authorized parties (i.e., attorney, school, parents, parent coordinator, guardian-ad-litem, etc.). Time spent reviewing records and preparing reports/letters, preparing for depositions/court appearance, or any other services rendered by the treatment provider in this matter will also be billed accordingly.

If services involve court appearances or a deposition (off-site), the fees will vary and include legal travel fees at $100 per hour (portal to portal). The parent and/or attorney requesting the treatment provider to appear in Court or a provide a deposition will be responsible for a minimum fee of 2 hours or the time frame requested for the provider to be available (plus travel costs if at a different location than the provider's office), payable 72 hours (3 business days) prior to the date of the required Court appearance or deposition. Cancellations less than 24 hours for court or any scheduled appointment will incur the full fee regardless of whether or not the provider testifies in court that day or provides the service.

A credit card on file is required for all services. Depending on the type of service, a retainer may also be required for commencement of services. Once the retainer balance is $500 or below, an additional retainer will be required to avoid a disruption in services. These services cannot, and will not, be billed to any health insurance provider for reimbursement.

If the retainer is not replenished and/or the credit card is not working, any amounts not paid within 30 days at the time of services, shall incur interest at the rate of eighteen percent (18%) per annum and computed monthly. A lien for the amount of the fee and expenses advanced shall exist in favor of the said provider, and said lien continues if said treatment provider is discharged. Failure to pay amount billed within thirty (30) days will be the basis for the treatment provider to withdraw from further services, and to do so without objection or complaint from the parent with a remaining balance. If you have any further questions, do not hesitate to discuss this directly with your treatment provider.

Fee for Services: $ 300 (45 min); $400 (60 min) **Fee for Court/Off-Site Services: $400 (60 min)**
Retainer amount (if applicable): $_____
Patient(s) Name:_____ **D.O.B.:**_____
Signature:_____ **Date:**_____
Responsible for payment ☐ No ☐ Yes - If Yes,_____% responsible

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Payment Responsibility and Agreement

Name of Patient:_____

At Pediatric Psychology Associates, our mission is to deliver exceptional care and meet the needs of our clients. To support continuity of care and provide clarity on our financial and scheduling policies, we kindly ask you to review the following guidelines:

Financial Responsibility

- Payment is required at the time of service unless prior arrangements have been made.
- The responsibility for payment of psychological services provided by PPA rests solely with the patient (caregiver/guardian if the patient is a minor).
- Patients are responsible for their scheduled appointment time, regardless of whether or not a courtesy email/text reminder of the appointment was sent.
- Consultation/Treatment Sessions: Standard consultation and treatment sessions are 45 minutes. Extended (60-minute) and double (90-minute) sessions are available and billed at a prorated rate based on the standard 45-minute session fee.
- Testing/Evaluation Services: Evaluation fees and payment structures vary depending on the specific service provided. *Please refer to the Deposit and Cancellation Policies for Testing/Evaluation Services* below.
- Additional Charges:
    - Charges for additional professional services, such as extended phone or email communications (over 10 minutes), consultations with other professionals (with your consent), preparation of records, written letter requests, treatment summaries, and other services requested outside of standard sessions, will be billed in 15-minute increments at a prorated rate based on the standard 45-minute session fee.
    - Services provided outside the office, including home/school visits or team meetings, may incur travel fees, which would be discussed with the patient in advance.
    - If professional services are required for legal matters (e.g., depositions, testimony, attorney consultations, or completing forms that require professional opinions), legal/forensic fees and policies will apply. Such details would be discussed with the patient at the time of inquiry/request for services.

Cancellation Policy for Consultation/Treatment Services

- **24-Hour Notice Requirement**: In the event a scheduled appointment needs to be cancelled, a minimum of 24 hours' notice is required. Appointments cancelled with less than 24 hours' notice are considered **Late Cancellations/No-Shows.**

- **New Patients:** Please note that new patients who do not provide 24-hour notice of cancellation or fail to attend their initial appointment will be required to submit all history documents, consents, and a credit card authorization form, with payment made in advance, before their appointment can be rescheduled.
- **Late Cancellations/No-Shows:**
    - For the first no-show or late cancellation a $100 fee will be assessed.
    - All subsequent no-shows or late cancellations will be charged at the full session rate. For extended sessions (60-90 minutes) and testing appointments, the time reserved will be billed.
    - Late cancellations/No-Shows due to illness require a doctor's note within 72 hours to waive charges. Charges will be applied but reversed upon receipt of the note.
    - If a patient becomes ill on the day of an in-office appointment, we ask to be notified as soon as possible. To ensure continuity of care and avoid fees for missed sessions, patients will be offered the option to convert the in-person appointment to a telehealth session with the patient and/or caregiver.
    - Emergencies eligible for fee waivers include critical hospitalization of a family member, family crises (e.g., a death), natural disasters, or accidents preventing attendance or timely cancellation. Documentation may be required, and each case will be individually reviewed.
- **Excessive Cancellations/No Shows & Recurring Appointments:**
    - After three (3) no-shows or late cancellations, therapy services may be terminated. If services are resumed, a credit card will be required to be kept on file and charged at the time the appointment is scheduled. Any future cancellations must be made more than 48 hours in advance to avoid termination of services.
    - If you frequently cancel a recurring (standing) appointment, even with advance notice, we may need to release your spot. Regular attendance is important to ensure scheduling runs smoothly and to allow other families the opportunity to utilize available times.

Office Cancellation Procedure:

- To cancel an appointment, patients must contact the **office via text or call (305) 936-1002 or email to appointments@mailppa.com**. If you are calling after hours or unable to reach our front desk team, please leave a detailed voicemail. While our phone system tracks all incoming calls and can verify the number, providing a clear message is essential to ensure your therapist is notified promptly and the necessary steps for rescheduling or follow-up care can be taken.
- While you may choose to email or text your provider directly, they are often in sessions and may not respond promptly. Therefore, it is crucial to cancel directly with the office, especially if the notice is given less than 24 hours before the appointment.
- Please note our automated email appointment reminders do not accept replies

Deposit and Cancellation Policies for Testing/Evaluation Services

Testing services require our clinicians to allocate multiple hours and at times coordinate schedules with other members of our team. Given scheduling complexities and level of commitment from our clinical team, we have established the following deposit and cancellation policies. These policies support smooth scheduling and availability for all patients, and ensure that our patients receive the full benefit of our services.

- **Deposit:**
    - For testing/evaluation services that are completed in one session, deposit of 50% of the total evaluation cost will be collected at the time the testing appointment is scheduled. This includes but is not limited to the following services (gifted, ADOS only, MDDC, school entrance, as well as any evaluation that is completed in one

session).This deposit will be applied towards the total balance due at the time services are rendered.
    - If multiple testing sessions are requested to be reserved in advance prior to the initial consultation, a deposit of 50% of the total evaluation cost will be collected at the time the appointments are scheduled.
- **Cancellations:**
    - For appointments that required a 50% deposit fee (single day testing or advanced scheduling):
        - Cancellations with More than 72 Hours' (3 business days') Notice: Evaluation appointments cancelled with more than 72 Hours' Notice (3 business days) will be eligible for a full refund of the deposit.
        - Cancellations with less than 72 Hours' (3 business days') Notice but More than 24 Hours' Notice: For evaluation appointments cancelled with more than 24 hours' notice but less than 72 hours' (3 business days) notice, the deposit will not be eligible for refund, but could be applied to a future, rescheduled appointment.
        - Cancellations with Less Than 24 Hours' Notice or No-Shows: If the scheduled testing appointment is cancelled with less than 24 hours' notice or missed without notice, the deposit will not be refunded. Exceptions would only include cases of emergencies or exceptional, documented circumstances, such as illness supported by a doctor's note. In the absence of such circumstances, the deposit is forfeited, and an additional 50% deposit will be required to reschedule the missed appointment(s).
    - For testing appointments that are cancelled with less than 24 hours' notice that have had an Initial Consultation and are completed over several sessions, the time reserved will be billed (at the consultation rate) for any scheduled appointment that is cancelled with less than 24 hours' notice.
- **Excessive Cancellations/No Shows:**
    - After three (3) Late Cancellations/No-Shows or Cancellations (regardless of the cancellation reason), testing services may be terminated. If services are resumed, a credit card will be required to be kept on file and charged at the time the appointment is rescheduled.

Thank you for your understanding and cooperation. These policies help us provide the best possible care to you and all of our clients. If you have any questions or need further clarification, please do not hesitate to contact our office.

Patient/Parent/Guardian Signature:_____

Printed Name of Signer:_____ Date:_____

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No Surprises Act- Good Faith Estimate of Costs

The purpose of this document is to let you know that PPA is an out-of-network provider with all insurance plans. If you prefer to use your health insurance, we would advise you contact your insurance company for a list of in-network providers. PPA does not accept insurance assignment, which means fees are not collected from insurance companies, rather they are paid directly by the responsible party. If you choose to submit to your insurance company the services you receive from PPA, your insurance may not cover some or all of the services.

With regards to an estimate of fees that will be paid for psychological services rendered, this will depend on the severity, duration, and diagnosis of the individual. Treatment length is variable and depends on numerous factors including how long the difficulties have been present. Current fee rates at PPA as of 1/1/2023, for Individual/Family Psychotherapy fees for a 45-minute session ($210 Master's Level and $300 Doctoral Level) and group psychotherapy is $90 a session. Fees are also reflected on our website at www.SouthFloridaTherapists.com. If fees change, you will be notified in advance. There may be additional items or services that are recommend as part of the treatment that will be scheduled separately and are not reflected in this good faith estimate. The information provided in this good faith estimate is only an estimate and actual items, services, or charges may differ from this good faith estimate. Nevertheless, you and your family members are free to discontinue treatment at any time. You can cancel sessions with 24 hours advance notice to avoid a fee.

If you have any questions or objections to any charge, please let the office know immediately. If unexpected costs arise, Federal law allows you to dispute the bill. You may start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There may be a small fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 800-985-3059.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care. This is not a contract and you are not required to obtain any services from PPA. However, if this is not signed, PPA is not able to provide and/or continue therapeutic care to you and/or your family members. If you have any additional questions, please direct them to your provider.

I understand and accept the above:_____ (signature)

Name of Patient/Responsible Party:_____ Date:_____

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CREDIT CARD PAYMENT CONSENT FORM

Patient Name:_____

Parent/Guardian:_____

Please charge my credit card: *(initial those that apply)*

_____ Retainer in the amount of $_____

_____ Recurrent charges after every service and for any outstanding balances

Type of Card: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder's Name (*as printed on card*):_____

Credit Card Number_____-_____-_____- _____

Expiration Date _____ CVV Number _____ 3-digit # back of the card (AMEX 4-digit # front of card)

Card Holder's Billing Address for Credit Card Statements:

Street Address:_____

City:_____State:_____Zip Code:_____

Best Contact Phone Number:_____

Best Contact Email Address:_____

Signature:_____ **Date:**_____

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HIPAA Notice of Privacy Practices- Effective Date: January 1, 2025

Pediatric Psychology Associates (PPA) is committed to protecting the privacy and confidentiality of your health information. This notice describes your rights under the Health Insurance Portability and Accountability Act (HIPAA) and explains how we may use and disclose your Protected Health Information (PHI). Please review this document carefully.

How We May Use and Disclose Your Information:

- **For Treatment:** We may share your PHI with other healthcare providers involved in your care to ensure you receive the best possible treatment.
- **For Payment:** We may use and disclose your PHI to process payments for services, such as submitting claims to insurance companies.
- **For Healthcare Education:** PHI may be used for quality improvement activities and other operational purposes within Pediatric Psychology Associates.
- **Required Disclosures:** We are required to disclose your PHI in certain circumstances, such as reporting abuse, neglect, or imminent danger to the appropriate authorities. We are also required your PHI to disclose if request by law enforcement or a court order/subpoena.
- **Authorized Disclosures:** We will not share your PHI with other family members, friends, or other third parties without your written consent, except in situations permitted or required by law.

Your Rights and Responsibilities - As a Patient/Parent/Guardian, you have the following rights and responsibilities regarding your PHI:

- **Access to HIPPA Notice:** You are entitled to a paper or electronic copy of this notice upon request.
- **Access to Medical Records:** You have the right to access and obtain a copy of your health records. You may request amendments to your health information if you believe it is inaccurate or incomplete.

- **Communications:** You may request to receive communications about your PHI.

- **Restrictions:** You may request that we restrict certain uses and disclosures of your PHI. While we will consider your request, we are not required to agree to all restrictions.

- **Accuracy of Information:** You must ensure the information you provide about your health history is complete and accurate. Notify us of any changes to your address, phone number, or other contact details. Please note that we encourage open communication regarding the potential need to share information with designated emergency contacts in critical situations.

  PPA reserves the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you, provided those changes affect your health information.

  If you have questions or concerns about this notice or your privacy rights, please contact us:

  Pediatric Psychology Associates - 305-936-1002 or info@mailppa.com
  Mailing Address: 2925 Aventura Blvd, Suite 300, Aventura, FL 33180

  Acknowledgment of Receipt

  I acknowledge that I have reviewed the HIPAA Notice of Privacy Practices provided by PPA (and can obtain a copy when requested).

  Name of Patient: _____

  Patient, Parent or Guardian Signature:_____ Date:_____

  If refused, reason for refusal:_____

  Restrictions noted:_____

info@mailppa.com
www.SouthFloridaTherapists.com
(305) 936-1002 (305) 936-1022
South Florida & New York Tri-State Area
Telepsychology Across PSYPACT States

Telehealth Policies and Procedures

Pediatric Psychology Associates (PPA) provides Telehealth Services when appropriate. This document has procedures for those services along with important information about PPA's Telehealth Policies. ***Please read this document completely and save it for your records.***

1. **Platform:** PPA uses RingCentral (a HIPAA compliant platform) for its Telehealth Sessions. RingCentral is accessible through a web browser on your computer and/or a free app download. You will be provided a link to use to connect to your Telehealth session in advance of your sessions.

2. **Disconnections:** In the case of a disconnection during your telehealth session, please attempt to reconnect. If it is not possible to reconnect, please call the office at 305-936-1002. Your therapist may opt to continue your session by phone or to reschedule.

3. **Etiquette and Location of Telehealth Sessions:** The convenience of telehealth sessions along with our tendencies to multitask while communicating via technology often leads patients to see telehealth sessions differently than an in-office visit (e.g. try to get their session done "on the go" or while doing other things). Approaching a telehealth session in this manner frequently leads to distractions, interruptions during the session, loss of privacy, and an overall reduction in efficacy of treatment. **It is very important that you treat your telehealth session just the same as an in-office visit.** That means that you will need to be in a quiet, private place that is free of distractions and interruptions. You should close all other applications and put your devices on silent or "do not disturb" mode so you can give 100% of your focus to your session. You should also be sitting upright in a seat (as opposed to lying down in bed or on a couch, walking around, etc.) **If at the time of your session your therapist finds that you are not in a suitable location for the appointment, he/she may choose not to continue with the session, at which point the session will be treated as a no-show/late cancellation.**

4. Patients agree to refrain from recording, photographing, reproducing, publishing or otherwise maintaining copies of sessions.

5. Because you are not physically in an office to remit payment, arrangements for payment for Telehealth Sessions will be made in advance of the session.

6. If you are receiving Telehealth Services, it is essential that we have a plan for emergencies. You are required to provide the following information along with consent to contact and communicate with these parties, including sharing health care information if deemed necessary:
    a. Name and contact information of an emergency contact person who can help in case of a crisis.
    b. Name and phone number of the closest emergency room to your location.

If you have any questions regarding our Telehealth Policies and Procedures, please do not hesitate to discuss them with your therapist.

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Telehealth Services Agreement and Informed Consent

I _____ (Patient/Guardian name) hereby consent to participating in Telehealth Services with Pediatric Psychology Associates (PPA).

Telehealth services are defined as communication between yourself and our organization via telephone, email, text message, video conferencing, or any other remote means that utilizes electronic transmitting technology. This includes what is defined as "teletherapy" (psychotherapeutic intervention done remotely via videoconferencing or telephone), as well as use of technology for administrative purposes (e.g. emails and phone calls regarding scheduling appointments). I understand that Telehealth allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment. This Consent Form covers all forms of electronic communication (teletherapy and administrative).

1. I have a right to confidentiality with telehealth services under the same laws that protect the confidentiality of my medical information for in-person psychotherapy, as noted in PPA's Informed Consent Form.

2. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective, and this includes Telehealth Services.

3. I understand that Telehealth Services risk technological failure that could cause distortion or complete disruption.

4. I have the right to withhold or withdraw this consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

5. I understand that PPA uses HIPAA compliant methods for Telehealth Services. However, no use of technology can be 100% protected. I also understand that the confidentiality of any text messages, emails, or voicemails I choose to keep is my responsibility and not the responsibility of PPA.

6. I consent to my provider contacting my emergency contact or local emergency services if a situation arises that requires immediate intervention. This may include sharing private healthcare information if deemed necessary.

Emergency Contact Person	**Local Emergency Services**
Name:	Nearest Hospital Name:
Relationship to Patient:	Phone:
Phone:	

I acknowledge that I have read and understand this important information regarding Telehealth Services.

_____ _____ _____

Patient/Guardian Printed Name Patient/Guardian Signature Date

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PSYCHOLOGICAL RECORDS AND PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ **DOB:** _____

I, undersigned, voluntarily request and authorize the personnel at Pediatric Psychology Associates (PPA) to obtain from and/or release to the agency(ies)/individual(s) I have indicated below the information contained in my and/or my family's clinical and medical record. I authorize PPA to release and/or obtain this private information verbally, in writing and/or electronically. I understand the purpose of the release/sharing of information may include clinical information, treatment planning, consultation, protection of self or others, coordinating interventions, educational planning, billing and collections, etc.

Check all that apply: I hereby authorize PPA to: ☐ release to and ☐ receive information from

Name/Agency	Contact Information (address, phone, email, fax, etc.)

I authorize PPA to (check one):

☐ Release any or all medical records

☐ Release specific information - please list here:

This authorization shall expire on (please check the box that applies):

☐ Date ☐ Treatment Termination ☐ No Expiration Date

By signing below, I agree to the exchange of the above information. I acknowledge that the nature of this information has been discussed with me in a manner that I understand, and that I have had an opportunity to have any questions regarding the above exchange of information explained to me. I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations. I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to one of PPA's offices.

Signature of Patient/Authorized Representative _____

Printed Name of Signer_____ Date _____