

Notice of Privacy Practices

Uses and Disclosures

Assessment and Treatment:

You or your dependent's health information may be used by staff members or disclosed to other care professionals for the purpose of evaluation, diagnosis of health conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your health record to all health professionals who may provide treatment or who may be consulted by staff members.

Consultation and Case Presentations:

You or your dependent's *de-identified* health information including but not limited to testing results and social history may be used or communicated to relevant professionals and relevant Insight staff for the purposes of case consultation and presentation. In all cases, your anonymity will be maintained.

Law Enforcement:

You or your dependent's health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, for the protection of yourself and others, and to comply with mandated government reporting, as required by law. In addition, Insight Neurocognitive Health is compelled to respond appropriately to any and all court subpoenas.

Other Uses and Disclosures Requiring your Authorization:

Disclosure of your health information or its use for any purpose other than those listed above requires your specific, written authorization. You may submit a written revocation of the authorization at any time. However, your decision to revoke the authorization will not affect or reverse any use or disclosure of information that may have occurred before you notified us of your decision.

Additional Uses of Information:

You or your dependent's health information may be used by our staff to remind you of your appointment.

Information about Treatments:

You or your dependent's health information may be used in order to send you information concerning the treatment and management of your condition. We may also send you information regarding other treatments, options, or related services recommended following your evaluation.

Note:

Insight Neurocognitive Health and its providers are required by law to protect the privacy of you and your dependent's protected health information and to provide you with this notice of privacy practices. We are also required by law to abide by the privacy policies and practices that are outlined in this notice.

Individual Rights:

- You and your dependent have certain rights under federal privacy standards. These individual rights include the following:
- The right to request restriction on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom you or your dependent's protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Right to Revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information:

As permitted by federal regulation, we require that any request to inspect protected health information must be submitted to us in writing. You may obtain a form to request access your records by contacting us directly.

Request for Restrictions on Protected Health Information:

You have the right to request us to restrict how we use and disclose your protected health information. However, we are not required by law to agree with your requested restrictions in certain situations. These situations may include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and/or any uses and disclosures described previously in this notice. However, if we decide to grant your request then we are bound by your agreement.

By signing below, I am hereby certifying that I have read, agreed to, and received a copy of the Privacy Practices for Insight Neurocognitive Health

Parent/Legal Guardian Signature

Date

Patient Name

Authorization for Release of Protected Health Information

Your child’s health record is private and is known under the law as “Protected Health Information (PHI).” By completing and signing this form, you (as parent, legal guardian, or legal representative), agree to allow Insight Neurocognitive Health (and its associated organizations subsidiaries, affiliates, employees, agents and subcontractors) to share your child’s PHI with the individuals or organizations listed below.

- NEUROPSYCHOLOGICAL EVALUATION REPORT *and related information both verbal and written*
- PSYCHOLOGICAL EVALUATION REPORT *and related information both verbal and written*
- OTHER REPORT *and related information both verbal and written* _____

This information should only be released to the following person(s)/agencies:

1. _____
2. _____
3. _____
4. _____

This authorization shall remain in effect for 12 months (1 year) or until such time that it is revoked.

Start: _____ End: _____

As parent, legal guardian, or legal representative, I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address below. However, I cannot revoke any copies of my report that have already been sent out based on my earlier permission to do so. In addition, I cannot revoke my permission to send a copy of the report to my insurance company, if that was a condition of obtaining insurance coverage, and thus the insurer has the legal right to contest the claim.

Send written notification of revocation of authorization for release of protected information to:

Insight Neurocognitive Health
Suite 1900
4800 S Saginaw St.
Flint, MI 48507

I understand that once I authorize the release of records to another person and/or agency, that there is no guarantee that such records will remain in confidence, and that it is possible that my records may be sent to other individuals.

I understand that my decision to sign or not to sign this authorization will not affect the provision of psychological services by Insight Neurocognitive Health.

For patients/clients who are legally incapable of giving informed consent, the following apply:

1. An appropriate explanation will be provided
2. Assent will be sought from the individual
3. Consideration of the individual's preferences and best interests
4. Obtain appropriate permission from a legally authorized person, if such substitute's consent is permitted or required by law.

Printed, Full name of Client (**or Authorized Representative***)

Client Signature (**or Authorized Representative***)

Date

Witness Signature

Date

*If the authorization is signed by a personal, authorized representative of the patient, then a description of such representative's authority to act for the patient must be provided below:

Authorization for Release of Health Information

I, _____, as parent, legal guardian, legal representative of
(Print parent, legal guardian, legal representative full name)

_____ (_____)
(Print Child's full name) (Child's date of birth)

hereby authorize the release of my child's health information from:

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax: _____

to the following recipients: **Insight Neurocognitive Health** **Other**

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax: _____

(Please use the back of this form if more recipient space is needed.)

Information Requested:

I understand and acknowledge that this may include the release of any information pertaining to alcohol/drug abuse, mental health, or HIV/AIDS. I give my permission for the information listed above to be released to the above-named recipient(s). I understand that I may revoke this authorization at any time, except to the extent that action has already taken place to comply with the authorization. This authorization will expire in 90 days after the date signed below. The recipient(s) of said information should not re-disclose any medical records to any third party without further written consent.

Patient Signature (or Authorized Representative)

Date

Witness Signature

Date

Informed Consent Form

Psychological/Neuropsychological Testing

This document contains important information about testing services at Insight Neurocognitive Health. Please read and sign at the bottom to indicate that you have reviewed and that you understand this information in its entirety.

Purpose:

Your child has been referred for an evaluation that will help you to better understand the relationship between behavior and nervous system functioning, current neurocognitive functioning, and any strengths and/or deficits thereof. The information obtained will help define the existing problem(s) and its trajectory as well as help in determining treatment options.

Procedure:

The testing process involves a clinical interview, a neurobehavioral status examination to further define your child's condition, and the completion of a variety of neuropsychological and psychological tests. The total time of the evaluation may vary, and it will depend upon your child's levels of functioning and performance, the nature of his or her condition and how it may impact his or her performance, and the number and nature of tests administered.

Time Commitment:

The full evaluation process typically includes 1-2.5 hours for the initial clinical interview and associated neurobehavioral status exam (i.e., the first appointment). Subsequent testing can last from anywhere between 2 and 6 hours depending on the nature and complexity of the case. Additional time after testing will be required to score and interpret the testing results and generate a report. A final 1-hour meeting (feedback session) will be scheduled, in most cases (with some exceptions), to discuss the testing results and treatment recommendations. Common features of evaluations typically include the following:

- ❖ Review of Relevant Records – background information that enables the evaluator to have a historical context that benefits the testing situation.
- ❖ Clinical Interview/Neurobehavioral Status Exam – the evaluation with the client contains (1) his or her background information, such as family history and past/present physical health, (2) mental health concerns, such as symptoms of distress, substance abuse, (3) educational, employment history (if applicable), and a (4) neurobehavioral status exam. Collateral contact may also be obtained to facilitate the process. The licensed psychologist is the person who will perform the clinical interview/neurobehavioral Status Exam.
- ❖ Testing – tests will assess cognitive ability as well as emotional status; these are either computerized or paper and pencil tests. Most tests are interactive and will be administered by Dr. Franke, or in some cases, a qualified testing technician under the supervision of Dr. Franke.

Confidentiality:

All information disclosed during the evaluation is kept private and protected. Information that is shared will be kept strictly confidential and will *not* be disclosed outside of Insight Institute of Neurosurgery and Neuroscience (i.e., to 3rd party without the written consent from the child's parent, legal guardian, or legal representative. By law, however, confidentiality is not guaranteed in the following situations: (1) the patient (or representative as described above) directs me to tell someone else, in writing, (2) It is determined that the patient is a danger to themselves or to others, (3) A court order is levied to disclose the information, (4) It is suspected that child or elder abuse has occurred, and/or (5) the insurance company of the responsible party requests that information. If a patient is under the age of 18 years, their legal guardian must read and sign this form

Complaints:

In the event that you are dissatisfied with our services for any reason, please do not hesitate to contact us and let us know.

Insight Neurocognitive Health

Suite 1900

4800 S Saginaw St.

Flint, MI 48507

Foreseeable Risks, Discomforts, and Benefits:

The evaluation process in its entirety can be lengthy. Some people may experience discomfort when discussing or recalling their personal and medical history. In addition, the evaluation process can cause fatigue, anxiety, and frustration for some individuals. Reasonable steps will be taken to mitigate these factors and to provide you with a safe and comfortable atmosphere and experience. Some people may also experience discomfort with the results of the evaluation, especially if those results end up being unexpected for the patient. We will take reasonable steps to explain and clarify any information resulting from the evaluation and answer any questions that you may have. This is done primarily at the time of your feedback session.

Freedom to Withdraw:

The patient (or representative as described above) retains the right to end the evaluation at any time. If the patient (or representative as described above) wishes to do so, Insight Neurocognitive Health is able to provide the names of other qualified professionals that may help in completing the evaluation.

Informed Consent:

I, as **legal** guardian or representative of my child, have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I give consent for Neuropsychological/Psychological testing.

I have discussed with Dr. Franke the various aspects of the evaluation itself. This has included a discussion of the preliminary evaluation and clinical impressions, as well as the purposed method of evaluation. I understand the limits to confidentiality, the scheduling policy, the fee policy, the policy regarding missed or cancelled appointments, and the emergency procedures.

Psychologist's Signature
Timothy Franke, PsyD, LP

Date

Parent/Legal Guardian Signature

Date

