Consent for Assessment, Payment, and Health Care Operations, and Acknowledgement of Receipt of Notice of Policies & Practices to Protect the Privacy of a Patient's Health Information

Welcome to the Psychological Assessment Clinic (PAC), part of the Psychological Services Center (PSC) at the University of Mississippi. This consent and acknowledgement document contains important information about our professional services and business practices, special conditions related to being a graduate student training clinic, and information about the Health Insurance Portability and Accountability Act (HIPAA). We encourage you to read it carefully and to ask any questions you may have. We will give you a copy to take home.

SUPERVISION AND TRAINING:

Services at the PAC are primarily provided by graduate student clinicians in the clinical psychology program at the University of Mississippi, who are under the direct supervision of a licensed psychologist. The supervisor's name will be provided to you during your initial appointment at the PAC. Some services are also provided directly by licensed psychologists. It is standard procedure for sessions to be videotaped for supervision and educational purposes. Student clinicians are supervised either on an individual basis or in a student clinician group. One of the main purposes of supervision and training is to assist our clinicians in providing the best possible services to their clients.

WHAT IS ASSESSMENT?

Assessment services through the PAC typically consist of a thorough process of gathering information about a client's history (i.e., developmental, medical, psychological, educational, family, and social); conducting structured and semi-structured interviews; completing standardized self- and other-report measures; and administering psychological testing or assessments. Assessment clients typically are seeking information about a specific question (e.g., "Does my son have ADHD?"), academic accommodations, or documentation for medication purposes. Assessments are usually completed in two 4-hour sessions, with a 1-hour feedback meeting to discuss the results of testing, diagnoses, and recommendations that are provided in a comprehensive written report.

BENEFITS TO ASSESSMENT:

Possible benefits to assessment include improved cognitive or academic performance and awareness of strengths and limitations.

FEES AND INSURANCE REIMBURSEMENT:

We are committed to providing high quality clinical assessment and treatment services. Since the PSC's primary purpose is clinical training, our fees are modest and adjustable. The full fee is generally set at about 50% of community rates. Clients with specific financial difficulties are encouraged to discuss the matter with their clinician or the clinic manager. Assessments are paid 100% at the first session, but may be paid 50% at the first session and 50% any time before the feedback session. Checks should be made out to "PSC."

The Psychological Services Center does not bill insurance companies. Although the PSC will not file an insurance claim for you, you may request that we provide you with a comprehensive statement that you can send to your insurance company for reimbursement. We cannot ensure payment by third party payers and it is your responsibility to verify coverage if you plan to seek reimbursement. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, your name, address, phone number, nature of services provided, and amount due may be forwarded to a collection agency in accordance with State policies and procedures.

MISSED APPOINTMENT POLICY:
Assessments take several meetings to gather the data necessary to answer the specific clinical question for which an assessment is sought. They require assessors to devote a significant amount of time and, because of their time-sensitive nature, typically must be completed within a matter of weeks. Therefore, if you cancel, reschedule or miss more than one appointment or if there is more than one month between any of the assessment sessions, we may determine that we have to complete the assessment with the data collected up to that point.

IN CASE OF EMERGENCY:
The PSC does not have 24-hour emergency coverage. In the event of an emergency, you may contact any of the following resources if you need urgent care:

1. Call 911, the National Suicide Prevention Lifeline (800) 273-8255, or the Emergency Department of the hospital nearest to you.
2. University of Mississippi students, faculty, and staff may contact the University Counseling Center (UCC) at 662-915-3784 for crisis services after regular business hours, during weekends, or during a holiday. Regular hours for UCC in-office crisis services at 220 Lester Hall are Monday-Friday from 12:00 pm - 4:00 pm.

HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT:
The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections for treatment records and establishes patient rights with regard to the use and disclosure of your Protected Health Information (PHI). PHI is your medical, billing, and demographic information collected and created or received by the PSC for the purposes of treatment, payment, and health care operations. HIPAA also permits use of PHI for teaching purposes. HIPAA requires that the PSC provide you with a Notice of Privacy Practices. Our Notice, which is included with this document, explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that the Clinic has provided you with this information.

LIMITS ON CONFIDENTIALITY:
Both Mississippi and federal law generally protect the privacy of communications between a client and a psychologist. In most situations, the PSC cannot release information about your treatment to others unless you sign a specific written authorization or consent. However, there are certain situations in which the PSC is mandated or permitted to disclose confidential information without your consent or authorization. These situations are outlined in the included Notice of Privacy Practices and include: 1) abuse, abandonment, or neglect of a child; 2) abuse, neglect, or exploitation of a vulnerable adult; 3) reported harm of self or another identified person; and 4) if a court order is issued to obtain records. If such a situation arises, your clinician will try to contact you before taking any action and will limit disclosure only to the information minimally necessary in the situation.

CONSENT AND ACKNOWLEDGEMENT:
I understand I have the right to review the Notice of Privacy Practices prior to signing this document. This Notice describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills, or in the performance of health care operations of the PSC. The Notice also describes my rights and the PSC's obligations with respect to my PHI. The PSC reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by contacting the PSC and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I consent to the use and disclosure of my Protected Health Information by the PSC for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment, and/or conducting health care operations of the PSC. I understand that diagnosis or treatment of me by the PSC is conditioned upon my consent as evidenced by my signature on this document.

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I may revoke my consent in writing at any time. That revocation will be binding when received by the PSC except to the extent a) the PSC has already taken action in reliance on my consent, b) the PSC has legal obligations imposed by a court of law that makes continued use and/or disclosure of my PHI, or c) I have not satisfied financial obligations to the PSC that I have incurred.

My signature on this document is my consent for treatment, payment, and health care operations and my acknowledgement that I have been informed about and received a copy of the PSC's Notice of Privacy Practices. I understand that I have the right to ask questions of my clinician about the above information at any time.

Client Name: ____

Client Signature: _____________________________________ Date: ___________

The client is a minor and I, as their parent or guardian, give my consent to the assessment on the terms described above, and I acknowledge that I have been informed about and received a copy of the PSC's Notice of Privacy Practices. I understand that I have the right to ask questions of my child's clinician about the above information at any time.

Parent/Guardian Name: ________________________________

Parent/Guardian Signature: ______________________________ Date: __________

I the undersigned, am an authorized representative of the Psychological Services Center and have witnessed the above signatures on the date they provided.

Witness Signature: ____________________________________ Date: __________

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