899 Logan Street, Suite 307
Denver, CO 80203
(303) 756 1197

Welcome to Elevated Insights Assessment, LLC. This document contains important information about the professional services, how mental health information about you may be used and disclosed, and how you can access this information. Please read it carefully and discuss any questions you may have.

DISCLOSURE STATEMENT & POLICIES

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. Elevated Insights Assessment, LLC ("EIA") is located at 899 Logan Street, Suite 307, Denver, CO 80203, 303-756-1197. Please see the listing of clinicians below for educational background and specific trainings and qualifications of each of EIA's clinicians or refer to our website at www.elevatedinsights.org.

Dr. Kate Colón is co-founder of Elevated Insights. Kate has a Doctorate in Clinical Psychology from the University of Denver (DU) in Clinical Psychology (2014), a Master's Degree in International Disaster Psychology from DU (2010) and her Bachelor's Degree in English Literature from the University of Montana (2003). She is a Licensed Clinical Psychologist in the state of Colorado # 4327.

Dr. Jennifer Paz is co-founder of Elevated Insights. Jennifer has a Doctorate in Clinical Psychology from the University of Denver (DU) in Clinical Psychology (2015). She earned her Master's Degree in Clinical Psychology from DU (2013), Masters of Education from Regis University (2007), and her Bachelor's Degree in Psychology from Georgia State University (2003). Jennifer is currently a Licensed Clinical Psychologist in the state of Colorado #4497.

Dr. Jenna Scott has a Doctorate from The George Washington University in Clinical Psychology (2014), a Master's Degree in Clinical Psychology from The George Washington University (2011), and her Bachelor's Degree in Psychology from the University of Nevada Las Vegas. Jenna is a Licensed Clinical Psychologist in the state of Colorado #4736.

Dr. Kelsey Hyde has her Doctorate from the University of Denver (DU) in Clinical Psychology (2019). She earned her Master's Degree in Clinical Psychology from DU (2017) and her Bachelor's Degree from Grinnell College (2011). Kelsey is currently supervised by Dr. Jennifer Paz and is a Postdoctoral Candidate earning her hours towards licensure.

2. Everyone thirteen (13) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for his or her minor child/ren, must sign this disclosure statement on behalf of his or her minor child under the age of thirteen (13) years old. This disclosure statement contains the policies and procedures of EIA and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

3. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Clinicians, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. Clients are encouraged, but not required, to resolve any grievances through EIA's internal process.

4. You, as a client, may revoke your consent to treatment and/or assessment or the release or disclosure of confidential information at any time in writing and given to your Clinician.

5. Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. Licensed Social Worker must hold a masters degree in social work. Psychologist Candidate, a Marriage and Family Clinician Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. Licensed Clinical Social Worker, a Licensed Marriage and Family Clinician, and a Licensed Professional Counselor must hold a masters degree in his or her profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. Registered Psychotherapist is a psychotherapist listed in Colorado's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. Registered Psychotherapists are required to take the jurisprudence exam.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

As a client you are entitled to receive information from me about my methods of therapy and assessment, the techniques I use, the duration of your therapy and/or assessment, if I can determine it, and my fee structure. Please ask if you would like to receive this information.

Fees:

1. My fee structure, services, and fee policy are outlined as follows (see additional fee sheet for assessment fees):

a. $150.00 per hour and $175.00 for the initial intake. The estimated total cost of the evaluation, which is subject to change is: $_____.

b. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

c. EIA is paneled with the following insurance carriers: Kaiser Permanente Colorado and Health First Colorado. If you have qualifying medical Medicaid coverage for neuropsychological assessments which include cognitive, adaptive and autism spectrum assessment, EIA may be able to offer psychological assessment services to you. If you have both primary insurance and Medicaid, your primary insurance must be billed first before Medicaid can be billed. If EIA has received a referral from Kaiser Permanente for autism spectrum assessment, we may be able to offer services to you.

EIA does not accept any other insurance carriers and is considered an out-of-network provider. EIA is able to provide you a superbill and/or statement for services rendered and will not submit to your insurance carrier for your reimbursement.

d. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $450.00 per hour.

Restrictions on Uses:
2. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however EIA is not required to agree to a restriction request. Please review EIA's Notice of Privacy Policies for more information.

Second Opinion and Termination:
3. You are entitled to seek a second opinion from another Clinician or terminate assessment and/or therapy at any time.

Sexual Intimacy:
4. In a professional relationship (such as psychotherapy and assessment), sexual intimacy between a psychotherapist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202.

Confidentiality:
5. Generally speaking, the information provided by and to a client during assessment and/or therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Clinician, Certified and Licensed Addiction Counselor, or a Registered Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

6. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out EIA's Consent for Communication of Protected Health Information by Unsecure Transmissions.

"No Secrets" Policy:

7. When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e. on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your Clinician is required to do so by law. However, in the event that you disclose information that is directly related to the assessment and/or treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the assessment process. Your Clinician will use her best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your Clinician will first give the individual the opportunity to make the disclosure themselves. This "no secrets" policy is intended to allow your Clinician to continue to assess and/or treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate Clinician who can treat you individually.

Co-Parent Consent:

8. When parents of a minor seek services from EIA, it is our policy to get consent from both parents and to review any custody agreement or court order regrading decision-making authority. It is the policy of EIA to be informed by parents of any changes or potential changes to the custody agreement or court order. Failing to do so may result in termination of therapy services. In most cases, the child/adolescent spends time in the custody of both parents. EIA has found that treatment and assessment can be counterproductive if one parent is resistant to services or if his/her feedback is not considered. We may miss important clinical information if we are not able to gather input from both parents. In the event that one custodial parent does not consent, or revokes consent, EIA will not provide treatment or will stop treatment until both parents agree to continue. If both parents are not able to agree on treatment with EIA, then EIA will make appropriate referrals.

There are two exceptions to this policy. First, if one parent's rights have been terminated or if full medical decision-making authority is given to only one parent. In this case, EIA will agree to see the child with the consent of the full custodial parent. Secondarily, in the event that an adolescent, who is fifteen or older, consents to his/her own treatment.

Extraordinary Events:

8. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Dr. Kate Colón or Dr. Jennifer Paz
ADDRESS: 899 Logan St. Suite 307, Denver, CO 80203
TEL: 303-756-1197
CREDENTIALS: Licensed Clinical Psychologist

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Maintenance of Client Records:

9. As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board, EIA will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, or seven (7) years after the age of majority, whichever is later. EIA cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records:
10. EIA may keep and store client information electronically on EIA's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, EIA may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. EIA may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

EIA may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. EIA uses a cloud-based service for storing or backing up information. The cloud-based backup system EIA uses is: Simple Practice and the email service provider EIA uses is: Simple Practice and One Drive. EIA may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information EIA has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures EIA employs, please ask.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that EIA may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with EIA's Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in EIA's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my Clinician may communicate with me via this method.

3. I understand that there may be times when my Clinician may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in assessment and/or therapy. My confidentiality is still protected during consultation by my Clinician and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my Clinician permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my Clinician.

4. I understand that, in general, EIA does not provide Teletherapy, such as therapy over telephone or video chat. I understand that communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. I understand that should I want Teletherapy, I will discuss my request with my Clinician. I understand that it is in my Clinician's sole discretion whether to accommodate my request for Teletherapy.

5. I understand that my Clinician does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other

friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that EIA has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" EIA's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on EIA's page/wall as well. I understand that any comments I post regarding therapeutic work between my Clinician and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my Clinician through the mode I consented to and **not** through social media.

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my Clinician and address those questions.
7. I understand my Clinician provides non-emergency assessment and therapeutic services **by scheduled appointment only**. If, for any reason, I am unable to contact my Clinician by the telephone number provided to me, 303-756-1197, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. EIA does not provide after-hours service without an appointment. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due**. I understand that if I leave a voicemail for my Clinician on the phone number provided, my Clinician will return my call by the end of the next business day, excluding holidays and weekends.

8. If my Clinician believes my therapeutic issues are above her level of competence or outside of her scope of practice, my Clinician is legally required to refer, terminate, or consult.

9. **I understand that I am legally responsible for payment for my assessment and/or therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my Clinician, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my Clinician to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my Clinician about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my Clinician's entire client file. I understand that once my insurance company receives the information I or my Clinician has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my Clinician a copy of any report EIA submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.**

Medicaid Providers:
10. Health First Colorado Member Billing Providers agree to accept the Health First Colorado payment as payment in full for benefits. Colorado law (C. R. S. 25.5-4-301 (II)) provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Health First Colorado. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service. This law also prohibits providers from billing Health First Colorado members for the estates of deceased Health First Colorado members for Health First Colorado benefits. As such, Health First Colorado members are not responsible for payment for late cancellations or failure to show for an appointment.

10. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

11. I understand that if I have any questions about my Clinician's methods, assessment techniques, or duration of

assessment and/or therapy, fee structure, or would like additional information, I may ask at any time during the assessment and/or therapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members as well as nurses, case managers, or other professional service providers associated with my care in assessment and/or therapy when deemed necessary by myself or my Clinician. I agree that these parties will have to **sign a separate Consent for Third-Party Participation Agreement** or may have to sign a separate disclosure statement in order to participate in therapy.

13. There is no guarantee that assessment and/or psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

14. Because of the nature of therapy and/or assessment, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the assessment and/or counseling process the therapeutic relationship must remain solely that of Clinician and client. This means that my Clinician cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to her relatives, friends, the relatives of friends, people known socially, or business contacts.

15. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my Clinician has a right to charge my credit card on file, or my account, for the full amount of my session. I understand that Medicaid cannot be billed for late cancellations or no-shows, however my Clinician reserves the right to terminate assessment or therapy services if I fail to show up for my schedule appointment or cancel with less than 24 hour's notice.

16. I also affirm, by signing this form, I am at least thirteen (13) years old and consent to assessment, treatment and/or therapy services here at EIA or that I am the legal guardian and/or custodial parent with the legal right to consent to assessment and/or treatment for any minor child/ren who is under the age of thirteen (13), for whom I am requesting assessment and/or therapy services here at EIA.

17. I understand that if I am consenting to assessment and/or treatment services for my minor child/ren that my Clinician will request that I produce, in advance of commencing services with EIA, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. Further, I understand and agree to keep my Clinician informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my Clinician from providing assessment and/or therapy to my minor child/ren. I understand that it is beyond the scope of my Clinician's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

Informed Consent for Psychological Assessment/Testing

Policies and Procedures for Psychological Services/Evaluations

This Informed Consent form is designed to explain the policies and procedures for an evaluation or psychological services with Elevated Insights Assessment, LLC. There is a separate consent form for treatment/counseling. Please thoroughly review this document as it contains information that is very important for you to know.

Additionally, the standardized testing norms may not be representative of your cultural and/or linguistic background therefore; at times this might require a non-standardized administration and scoring of the tests to be used.

Evaluation Services:

The evaluation process takes place in four primary stages:

1. Diagnostic interview to obtain a history, review concerns, discuss the reason for the evaluation, determine what testing needs to be one, and review informed consent and evaluation procedures.
2. Testing generally takes place in one or more 2-4+ hour sessions, but sometimes other arrangements may be made based on your needs or the needs or your child as determined during the diagnostic interview and subsequent assessment sessions.
3. Scoring, interpretation, reviewing previous clinical work, contacting collaterals, collecting background information and report writing by your Clinician: typically ranges from 5-20 hours. You will be charged at the hourly rate for any work of this nature that is completed prior to your assessment, even if you do not complete the full assessment and/or treatment.
4. Results and feedback conference with the client or their parents to provide testing results, interpretation, diagnostic impressions, and treatment recommendations.

In addition to the stages of the evaluation described above, other services are sometimes needed. It is often helpful for the evaluator to speak with other professionals who have worked with or are working with you or your child. This includes therapists, physicians, counselors, teachers, speech or occupational therapists. You will be asked to a additional written consents if this is necessary. A school observation may also be recommended by this Clinician to provide a better idea of how your child is functioning in the educational setting.

A comprehensive written report will be generated and copies will be provided to you as part of the evaluation costs. Typically, the written report is provided to you at the time of the results and feedback session. The results of the evaluation may not answer all questions about you or your child's situation. Thus, other referrals may be made to other service providers.

Benefits and Risks of Evaluation:

The primary benefits of an evaluation include diagnostic clarification, appropriate treatment recommendations to handle challenges and maximize strengths, a written report to facilitate services in the community or at school, and insight into the nature of your or your child's strengths and weaknesses. Although most individuals have a positive experience during the evaluation process, there are some risks. The person being evaluated may experience discomfort (frustration, anxiety, embarrassment, etc.). Also, it is possible that the evaluation will not answer all of your questions, and further evaluation may be needed. While the assessment and treatment recommendations are based on best practices, you or others may not agree with the conclusions based on your Clinician's professional judgment. It is your decision whether to follow the recommendations.

Consent for Psychological Services or Evaluation/Testing

I, _____, agree to allow the Clinician named below to perform psychological testing services for:

☐ myself

or

☐:_____

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the evaluator's time required for the reading of records, consultations with other Clinicians and professionals, scoring, interpreting the results, and any other activities to support these services. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail.

I understand that the fee for the initial 60-90 minute Diagnostic Interview is $175.00 and is due at time of service. My psychological evaluator will determine my testing needs based on this Diagnostic Interview. If I agree to my

evaluator's testing recommendations, I understand that I am fully responsible for the payment of these additional services, even though my health insurance or Medicaid may pay my Clinician or may repay me for some of these fees.

I understand that this evaluation is to be done for the purpose(s) of:

1. _____

2. _____

I also understand the Clinician agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association, the Health Insurance Portability and Accountability Act (HIPAA), and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above (In psychological terms, their reliability and validity for these purposes and population have been established). These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Any testing results containing my PHI will be stored in a secure filing cabinet along with the rest of my client file as well as being stored electronically through Simple Practice and One Drive.

I understand that a psychological evaluation is an interactive process between the client and evaluator. It is meant to promote understanding and treatment planning. Sometimes the process can be emotionally painful and other times it may be fulfilling. I have the right to choose my psychological evaluator or to refuse services. If I choose to end services for any reason I understand Elevated Insights Assessment will attempt to provide a list of qualified evaluators available to me. I understand that I should question the rationale of treatment if it is unclear to me. And while the evaluator has every expectation of helping, I understand they cannot guarantee any specific outcome.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate. My signature below confirms that I have read the above and agree to its terms and also serves as an acknowledgement that I have received the HIPAA Notice Form described above.

By signing this form, I affirm that I am fully informed of the assessment and/or therapy services I am requesting and that EIA is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary Clinician, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my Clinician.

_____ _____

Client Name/Signature DATE

_____ _____

Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

_____ _____

Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

_____ _____

Clinician Signature DATE

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA UNSECURE TRANSMISSIONS

This consent form is for the communication of Protected Health Information ("PHI") that Elevated Insights Assessment, LLC ("EIA") may transmit without the written authorization of the client as described in the Uses and Disclosure section of EIA's Notice of Privacy Policies.

I, _____, hereby consent and authorize EIA to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone this includes text messaging & voicemails
Please Insert Cell Phone Number: _____
_____ Unsecured Email
Client's Email: _____□ Send □ Receive
Please Circle One: Work Personal
_____ EIA Clinician's or Office Manager's Email: □ Send □ Receive
_____ Appointment/Scheduling Reminder System (Simple Practice)
_____ Other Media: Please describe: _____
_____ I do not wish to have my protected health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, EIA cannot guarantee that those communications will remain confidential. Even though EIA may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure our communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, consent to EIA transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ Information related to EIA's operations
_____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

_____ _____

Signature of Client/Parent/Legal Guardian DATE