Walter Scott Newsom, Ph.D. Texas
Licensed Psychologist # 31249
Phone 1-(855) 640-1700

Consent for Psychological Evaluation, Confidentiality Notice and Release of Information

General Information about Services Provided:

Dr. Newsom is a Psychologist licensed in the State of Texas for independent practice of Psychology. Dr. Newsom will only be performing an evaluation and will not be providing other clinical services. The evaluation may consist of any combination of clinical interviews, collateral interviews, behavioral observations, review of available records, psychological and neuropsychological testing.

Dr. Newsom will produce a written report of your evaluation and you will be offered opportunities for verbal feedback.

Exclusions and Limits to Confidentiality:

All information provided during the course of your evaluation is confidential. It is considered part of the medical record of the person who is evaluated and it is subject to all legal protections afforded medical records. Neither Dr. Newsom nor any of his associates will disclose any protected health information without a properly executed release.

There are exclusions and limitations to confidentiality. Anytime a professional has a reasonable suspicion that a child or other vulnerable person is subject to abuse or neglect, the professional is required by law to report to the appropriate governmental agency. When information is obtained that indicates a client appears to pose a danger to others or to him or herself, professionals will notify authorities. We are also required to turn over any requested information in response to a valid order from a court of competent jurisdiction.

Protected Health Information may be used internally by Dr. Newsom and affiliated businesses to conduct all transactions required to complete contracted services.

Payment:

If an **in-network insurance company** is being billed, we will file the claim for you. You are, however, fully responsible for the balance. It is not our policy to file claims for out of network insurance policies, although we can provide you with the paperwork to do this on your own. All co-payments, deductibles, percentages, and balances not covered by your insurance carrier are due and payable when services are rendered. You will be billed for any balances the insurance company does not pay. This balance is due and payable within 15 days of the statement date even if you plan to appeal a denial. No reports are released until all payments due are paid whether the payment is made by you or your insurance company.

If you are **paying privately**, we do not bill an insurance company. The full amount for the initial interview is due at the time of service. For testing, the estimated total is due and payable at the time of the first day of testing. Any balance is to be paid prior to the report being released.

For court appearances, a retainer will be required before the trial or deposition. Court appearances, depositions and other related activities are not covered in the price of the evaluation. If time constraints do not allow, balances will be due within 15 days of the statement date. If such payment is not possible because of

special circumstances, a specific payment plan must be agreed upon with the office manager prior to the beginning of services.

If your account is **not paid as agreed**, any balance over 30 days will accrue a late fee of 1 1/2 % per month (18% APR) or a late fee of $25, which ever is greater. Balances over 60 days old will start in collection procedures and a 20% collection fee, or a collection fee of $75, which ever is greater, will be added to the balance. You agree to allow us to perform all activities that go along with normal collections, including but not limited to obtaining a credit report. You agree to pay all added charges associated with the collection activity including all legal and judgment fees. You also acknowledge that the collection activity will be reported to and adversely affect your credit rating.

Consent and Release

By signing this consent form, I acknowledge acceptance of the financial arrangements.

Signing this consent authorizes release of protected health information to obtain payment for the services rendered.

Signing this consent authorizes Dr. Newsom to contact and consult with anyone deemed necessary to complete the evaluation.

Signing this consent authorizes Newsom Psychological full permission to use electronic transmission of any records obtained or produced as a result of this evaluation.

Signing this consent acknowledges that I have received a notice of my rights regarding protected health information under the Health Insurance Privacy and Accountability Act (HIPAA).

Having been given an opportunity to ask questions of the psychologist, I believe I understand the purpose of the evaluation and I agree to participate.

I am aware that I can revoke this consent in writing. Revocation does not apply to any information transmitted prior to revoking this consent.

I hereby consent to participate in the psychological evaluation as described above.

_____	_____
Signature	Date
_____	_____
Parent/Legal Guardian	Date
_____	_____
Parent/Legal Guardian	Date
_____	_____
Witness	Date

Walter Scott **Newsom PhD**
1-(855) 640-1700

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition(s) and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your provider, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to other organizations that provide care to you. In addition, your PHI may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assurance, employee review, training of student(s), licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to a student that sees patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your health care provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include, but not limited to: Suspected child abuse; suspected abuse of the elderly or disabled; as "Required by Law"; Public Health issues as required by law; Communicable Diseases as required by Public Health Law or the CDC; Legal Proceedings; Threats of danger to self or others; and FDA requirements. Under the law, we must disclose to you when the Secretary of the Department of Health and Human Services investigates or determines our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures

Will be made with your consent to authorize or object, unless required by law.

You may revoke this authorization

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your PHI

Under federal law, however, you many not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI

This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment of healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your provider amend your PHI.

If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this Notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

This Notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only an acknowledgement that you received this Notice of our Privacy Practices.

_____	_____	_____
Printed Name	Signature	Date

Walter Scott Newsom, Ph.D. Texas
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Authorization for Release of Confidential Information

Client's Name:_____ Date of Birth:_____

By signing below, I authorize Dr. Newsom and his associates to contact the persons and organizations specified below in regard to the contracted psychological services for the client identified above. I authorize Dr. Newsom to disclose confidential information during his contact with the entities below. I further authorize the entities below to speak candidly with Dr. Newsom and to release any requested information about the client identified above. Information to be disclosed may include, but not be limited to: Social, Medical, Educational and Psychological Reports, Medications, Treatment Goals, Results and Notes, Drug/Alcohol Use and Treatment, Court or Probation records and Academic Transcripts.

Name	Phone Number + email	Type of Professional

_____ _____
Printed Name of Client Signature of Adult Client

_____ _____
Signature of Parent or Guardian Signature of Parent of Guardian

_____
Witness