**Rachel E. Davis, PhD, PC**

Licensed Psychologist specializing in Pediatric Neuropsychology

# NOTICE OF PRIVACY PRACTICES

*THIS NOTICE DESCRIBES HOW YOU/YOUR CHILD'S HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.*

This document describes the privacy practices followed by Rachel E. Davis, PhD, PC. In it, I describe the ways in which I may use and disclose health information about you/your child and describe your rights and our obligations regarding the use and disclosure of that information. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Should I make changes, I will provide you with a copy of the revised notice by posting a copy on my website, sending you a copy in the mail when requested, or providing you the copy at our next appointment. Your privacy is protected by law.

**PROTECTED HEALTH INFORMATION (PHI)**
It is my responsibility, by law, to safeguard your/your child's PHI and to take precautions to keep it private. The law requires I provide you this notice; which applies to the information and records I have regarding your/your child's health, health status, and the services you/your child receive in our office. PHI can include:

1) information created and received by our office
2) spoken words, written, or electronic information
3) information about your diagnoses, examinations, health history, health status, procedures, prescriptions, symptoms, test results, treatments, and other health information

**YOUR RIGHTS REGARDING YOUR PHI**
I will not use or obtain your/your child's PHI without your written Authorization except as disclosed below. If you provide me with written Authorization to disclose your/your child's PHI, you may revoke that Authorization at any time in writing. Once you have revoked your Authorization, I will not disclose or obtain PHI about you/your child; however, I cannot undo any previous disclosures made when I had your permission.

**EXCEPTIONS TO WRITTEN AUTHORIZATION**
I may disclose your PHI for the following reasons:

1) ***Child or Elder Abuse***: As a mandated reporter, I am required to report all suspected cases of neglect, physical, or sexual abuse of a child to the Department of Human Services (DHS). I am also required to report suspected elder abuse or neglect to the Senior and Disabled Services Division.
2) ***Threats to Health or Safety***: I may disclose PHI if necessary to prevent clear and substantial risk of self-harm or intended harm to another individual. I am required to warn law enforcement and the intended victim in cases of clear and substantial risk of harm to another individual.
3) ***Lawsuits and Disputes:*** I may disclose PHI in response to a court or administrative order. I may also be required to disclose PHI in response to a subpoena.
4) ***Worker's Compensation***: I may provide PHI in order to comply with Worker's Compensation laws.
5) ***Contractual Obligations***: I may disclose PHI to third party contractors with whom I have a contractual relationship to provide services. For example, I may be contracted with a state agency that referred you/your child to me for an assessment, paid for the assessment, and who will receive a copy of the written report based on that assessment.
6) ***Verbal Permission:*** I may disclose your PHI to family members that are directly involved in your assessment or treatment with your verbal permission.

**USE AND DISCLOSURE OF YOUR PHI**

Your PHI can be used for the following purposes:

1) ***Treatment***: I may use PHI to provide you/your child with clinical treatment. I may also disclose PHI to other health care professionals who take care of you/your child. To use or disclose you/your child's PHI for these reasons requires your written permission.
2) ***Payment***: I may use or disclose PHI in order to bill or collect payment for the services I provide to you/your child. For example, I may need to disclose information to your insurance company in order to receive payment for therapy or an assessment I provided you/your child. I may also provide your information to business associates, which includes billing companies, claims processing companies, collection agencies, and others that process health care claims for my office. I require these business associates to safeguard your PHI to my standards.
3) ***Health Care Operations***: I may use and disclose information about you/your child in order to run the office and to make sure that you/your child receives quality care. I may also disclose PHI to health plans that provide your insurance coverage to assist them in improving care, reducing costs, coordinating, and managing health care.
4) ***Appointment Reminders***: I may contact you to remind you that you or your child has an appointment for assessment or treatment at the office.
5) ***Treatment Alternatives or Options***: I may contact you to tell you about potential treatment options or alternatives in which you may be interested.

**YOUR RIGHTS REGARDING YOU/YOUR CHILD'S PHI**

You have the following rights regarding your/your child's PHI:

1) ***Inspect and Copy***: You have the right to inspect and/or copy PHI. Please submit a written request to my office. I am allowed to charge you reasonable fees for copying ($0.60 per page for photocopies) and applicable mailing or other associated supplies. I may deny your request to inspect and/or copy in certain limited circumstances. Specifically, your right to inspect and copy PHI will be denied if there is compelling evidence that access to that information would cause serious harm to you. You may ask to have your request reviewed. If the law gives you a right to have my denial reviewed, I will select a licensed health care professional who was not associated with the denial to review your request and my denial. I will abide by that person's decision.
2) ***Right to Amend***: If you believe the information I have about you/your child is incorrect or incomplete, you can request in writing that I amend that information. I am not required to agree to this amendment. I will notify you of my decision to amend your PHI within 30 days.
3) ***Right to an Accounting of Disclosures***: You have a right to request that I provide you with a written account of any disclosures of PHI that I have made during the previous five years. This request must be in writing. I will provide one (1) accounting within a 12-month period free of charge. More than one request within 12-months will incur a reasonable charge equal to my customary hourly fee for therapy to cover the time necessary to fulfill your request.
4) ***Right to Restrictions***: You have the right to request a restriction or limitation on the PHI I use or disclose about you/your child for purposes other than treatment, payment, health care operations, or the other exceptions to written permission outlined above. You also may also limit the PHI I disclose about you/your child to someone who is involved in your/your child's care or payment for care (e.g., family member or friend). Please submit requests in writing to my office. I may not comply with your request if the information is necessary to provide you/your child with emergency treatment.
5) ***Right to Request Confidential Communication***: You have the right to request that I communicate with you in a specific manner, in a certain way or at a certain location (e.g., by nonsecure email, only at work, or by mail).
6) ***Right to a Paper Copy of This Notice***: You have a right to a paper copy of this notice and may request one at any time.

COMPLAINTS

If you believe your privacy rights have been violated you may file a complaint with the following agencies:

1) Rachel E. Davis, PhD, PC, (702-776-8990)
2) State of Nevada Board of Psychological Examiners (775-688-1268)
3) Secretary of the Department of Health and Human Services, office for Civil Rights

You will not be penalized or retaliated against if you file a complaint. Please ask for clarification if you have any questions about my privacy practices.

# NOTICE OF PRIVACY PRACTICES
## Receipt and Acknowledgment of Notice

Client's Name: _____ Date of Birth: _____

I hereby acknowledge that I have been given a copy of Rachel E. Davis, PhD, PC's Notice of Privacy Practices and have had a chance to read them. I understand that if I have a question about these privacy practices that I can contact Dr. Davis at (702) 776-8990.

_____ _____
Signature of Client, Parent, or Guardian Date

_____
Relationship to client

Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date

# COMMUNICATIONS POLICY

## *Contacting Me*

When you need to contact me for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

- By phone (702) 776-8990. You may leave messages on the voicemail, which is confidential.
- By secure email (see below for details.)
- If you wish to communicate with me by normal non-secured email, please read and complete the CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION form included with these office policies.

I subscribe to the following service that can allow us to communicate more privately through the use of encryption and other privacy technologies. This service will not cost you money but requires some setup before it can be used. Please ask if you would like to use this service:

- Encrypted email requires I send you an initial secure email. You will need to supply your email address on the client Contact Page of your intake packet or call the office and leave your email address with me or my office manager. My secure, encrypted email service is through MDofficeemail.com's Crypt-n-Send program.

If you need to send a file such as a PDF or other digital document, please send as an attachment using the secure email service mentioned above or please print and FAX it to (702) 776-8548. JPEG or other formats used when taking a picture (e.g., on your cell phone) are not clear copies. The original will also need to be provided before or at your first appointment.

It is important that we be able to communicate and also keep the confidential space that is vital to assessment or therapy. Please speak with me about any concerns you have regarding my preferred communication methods.

## *Response Time*

I may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within 24 hours (weekends and holidays are exceptions to this timeframe). I may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when I am unable to receive or respond to messages, such as when out of cellular range or out of town. We will discuss alternate contact methods during our sessions prior to my taking any sort of vacation.

## *Emergency Contact*

If you need to contact me about an emergency, the best method is:

- By phone (702) 776-8990, leave a message.
- If you cannot reach me by phone, please leave a voicemail and then follow up by calling 911.

## *Disclosure Regarding Third-Party Access to Communications*

Please know that if we use electronic communications methods, such as email, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations with whom you are affiliated. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

# Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your assessment or treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethical considerations and the law.

If you have any questions about this policy, please feel free to discuss this with me.

## Communication by Unencrypted Email and Other Non-Secure Means

It may become useful during the course of your assessment or treatment to communicate by email or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with this office or with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with me or my office
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you do not want access these communications, please talk with me about ways to keep your communications safe and confidential.

I also offer the use of secured, encrypted email service that requires the use of passwords to access and that store and transmit data (i.e., our communications) in an encrypted format. This secure method of email communication may also contain a limited amount of risk should an unauthorized person access your password or hack the secure service that I use. With this limited risk in mind, you may send me intake packets or therapy related information via this method. If you request, I will also send you written reports and/or the medical records to which you legally have rights to access via this method.

**Text Messaging**
Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me.

**Social Media**
I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Linkedin, and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

**Websites**
I have a website that you are free to access (drracheldavis.com). I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the

information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

**Web Searches**
I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown.

If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment. Additionally, please keep in mind that there are several individuals on the internet that have the same name as I and who are also psychologists. This fact can cause some confusion when you search for information about me online. Please feel free to verify and clarify the information you find online about me during our sessions.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

# CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION

I, _____
(client name or client's legal guardian)

AUTHORIZE: Rachel E. Davis, PhD, PC

7341 W. Charleston Blvd., Ste. 140

Las Vegas, NV 89117

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY AND/OR MY CHILD'S HEALTH RECORDS AND HEALTH CARE TREATMENT:

- O Psychological or Neuropsychological Reports
- O Information related to the scheduling of meetings or other appointments
- O Information related to billing and payment
- O Completed forms, including forms that may contain sensitive, confidential information
- O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- O My/my child's health record, in part or in whole, or summaries of material from that health record
- O Other information. Describe: _____

BY THE FOLLOWING MEDIA:

- O Unsecured email
- O Encrypted email
- O U.S. Mail
- O Voicemail messages
- O Other media. Describe: _____.

TERMINATION

O This authorization will terminate 365 days after the date listed below.

OR

O This authorization will terminate when the following event occurs:
upon completion of assessment, which includes delivery of the written report.

OR

O This authorization will terminate when the following event occurs:
upon termination of therapy services.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that **I am not** required to sign this agreement in order to receive treatment or assessment services. I also understand that I may terminate this authorization at any time.

_____ _____
Signature of Client, Parent, or Guardian Date

_____
Relationship to client

# INFORMED CONSENT FOR ASSESSMENT

This document contains important information about my professional services and business policies. It also provides me with very important information related to your child's development and the assessment that you are seeking. Please read these pages carefully so that you can make an informed decision about participating in psychological services. Please write down any questions you have so that we can discuss them at our first meeting. Your decision to participate, or to have your child participate, in psychological assessment is voluntary. When you sign this document, it will represent an agreement between us. Please complete all items to the best of your knowledge.

**Assessments**
Mental health providers, physicians, educators, and other service providers often recommend Neuropsychological, Psychological, Psychoeducational, and Developmental assessments to assist with both diagnosis and determining appropriate accommodation, intervention, or treatment approaches.

Assessments can have benefits and risks. As assessments often involve discussing difficulties or challenges, you or your child may experience uncomfortable feelings. On the other hand, comprehensive assessment has also been shown to have benefits such as increased understanding of individual strengths and weaknesses and increased access to appropriate services.

Assessments involve a parent or guardian interview (when the client is a minor), client interview, review of records, behavioral observations, self-report checklists, individually administered assessments, written report and a feedback session for the purposes of discussing results. Assessments last between 6 to 16 hours, including the initial appointment, 2-3 testing sessions, report writing, and feedback session. The completed assessment report will be available within □□ business days following the final session.

*Please note: The completed assessment report can only be interpreted by a trained professional and is not intended for any other purpose.*

## APPOINTMENT SCHEDULING AND CANCELLATION POLICY

I understand that the clients who seek my services appreciate timely and clear communication and as minimal a wait as possible to receive those services. Therefore, in an effort to streamline services and provide timely service to as many families as possible, the following is my policy regarding Scheduling, Cancellations, Rescheduling, and No show/No calls.

**Initial Appointment - Psychiatric Diagnostic Assessment**
During our initial appointment we will discuss the reasons you or your child has been referred for assessment. I will ask you and/or your child questions regarding symptom history and any previous services or assessments. I also will provide you with more information regarding future appointments, and what to expect during our time together. I typically schedule 1-1.5 hours for this first meeting.

**Testing Sessions**
Each testing session typically lasts □ to □ hours, depending on the age and developmental level of the client. Additional testing sessions may be scheduled if needed.

**Feedback and Follow-up Appointments**
Following the completion of testing, I will score the testing and self-reporting measures and review all records. I will then meet individually with the client (if an adult) or parents/guardians in order to review the assessment results, discuss any diagnoses, and outline any recommendations.

If the client is an older child or adolescent, I may also schedule a brief feedback appointment with the client in order to review any findings and recommendations with the parent who would like me to meet with the child.

**General Scheduling**
I, or my staff, will make two (2) attempts to contact you to schedule your *initial appointment*. In order to not pressure you regarding scheduling, if you do not return those calls within two (2) weeks we will not make further attempts to contact you. All subsequent appointments will be made at the end of the initial interview.

Similarly, I, or my staff will make two (2) attempts to contact families regarding scheduling the *feedback session* for assessment services. If you do not return those telephone calls, no further attempts to contact you will be made and the file will be closed if you do not contact my office within three (3) weeks.

**Cancellations and No Call/No Show for an Appointment**
Life happens and last minute emergencies can necessitate rescheduling an appointment. Given the limited number of appointments I can make per month, as much notice as possible is appreciated when a family needs to cancel/change an appointment. Therefore, I request a minimum of 24-hour notice before your scheduled appointment if you wish to reschedule. Cancellations made without this notice will incur a $100 cancellation fee. My office provides clients with reminder calls at least 24 hours in advance of their appointments. If you do not call to cancel and do not attend your scheduled appointment, you will be considered a "No Call/No Show" and will be charged the full fee for that appointment. You will be solely responsible for paying these fees, as insurance companies do not reimburse for them.

## GENERAL OFFICE POLICIES

My office is a safe and welcoming place for all individuals and families seeking psychological services. The following policies have been established in order to protect all individuals, family members, staff, and providers. If you are unable to comply with these policies, I retain the right to terminate your services.

- All adults, including parents, caregivers, spouses, and any other adult family members will behave appropriately towards me, my colleagues and staff, and any other individuals in the office.
- I expect all individuals, including clients and their family members to respect the privacy of all other clients and family members who come to this office. I ask that you not disclose the name or identity of other individuals you may see in my office.
- While waiting for their appointment or for their child to finish an assessment, I require parents and other visitors to maintain a quiet, peaceful environment. Please step outside if you need to take a phone call, use quiet voices, and maintain control of any other children waiting with you. You are responsible for any damage caused by your child(ren).
- Please keep in mind that the office door does open onto a parking lot. **It is crucial for their safety that you closely monitor your child(ren)** who may wander/elope out the door into a potentially dangerous area (i.e., the parking lot).
- It is highly important that you be immediately present should your child need you. Therefore, unless otherwise discussed with me, I expect you to stay on the property during your child's entire assessment. I have wifi guest access should you need to bring a laptop on which to occupy your time. I also have a selection of reading materials should you wish to borrow something to read.

# CONSENT FOR APPOINTMENT SCHEDULING/CANCELLATION AND GENERAL OFFICE POLICIES

**Agreement with Policy**

By signing here, you indicate you have read, understand, and will comply with the above *APPOINTMENT SCHEDULING AND CANCELLATION* and the *GENERAL OFFICE* policies.

Client or guardian signature: _____

Printed Name: _____

## PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep a record of our appointments and the services you receive from me. You are entitled to receive a copy of your records upon written request. Alternatively, I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. You may request that I correct the record if you believe an error has been made. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Nevada state law requires I maintain a complete copy of you/your child's health record for five years following the termination of services or until a client who is a minor at the time he/she received psychological services turns 23 years old, whichever is later. After that retention time has passed, I may destroy the record and maintain a summary of the record indefinitely. Until then, I will keep your records in a secure place. If I must discontinue our relationship because of illness, disability, or other unforeseen circumstances, I ask you to agree to my transferring your records to another psychologist or licensed mental health professional who will assure their confidentiality, preservation, and appropriate access.

## WHAT TO EXPECT FROM OUR RELATIONSHIP

As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the American Psychological Association (APA). In the interests of the client, the APA has placed the following limitations on the relationship between a psychologist and a client. I will abide by these limitations.

- I am licensed and trained to practice psychology. I am not licensed or trained to practice law, medicine, finance, or any other profession. I am not able to advise you in these areas.
- State laws and the rules of the APA require me to keep what you tell me confidential. Please see the Notice of Privacy Practices section of this document for more information.
- In your best interest, and following the APA's standards, I can only be you or your child's psychologist. I cannot have any other role in your life or your child's life. I cannot, now or ever, be a personal friend to or socialize with any of my clients or their family members. I cannot be a psychologist to someone who is already a friend or with whom I have had an intimate relationship. I can never have a sexual or romantic relationship with any client (or close relation of a client) during, or after, the course of assessment or psychotherapy. I cannot have a business relationship with any client (or close relation of a client), other than the psychological services relationship.
- In keeping with the standards of the APA, even though you might invite me, I may not attend your family gatherings, such as parties or weddings.

If you ever become involved in a divorce or custody dispute, I will not provide assessments or expert testimony in court. You should hire a different mental health professional for any assessments or testimony you require. This policy is based on the following: (1) My statements will be seen as biased in your favor because we have a previous professional relationship; and (2) the testimony might affect our professional relationship, and I must put this relationship first. By signing this form, you indicate that you understand and agree that I will not provide asssessments or expert testimony in court.

## STATEMENT OF PSYCHOLOGIST COMMITMENT

It is my intention to abide by all the rules of the American Psychological Association (APA) and by the laws of my state license. As in any other relationship, problems can arise in our therapeutic relationship. If you are dissatisfied with any area of our relationship, please address your concerns to me as soon as possible. I am committed to hearing your concerns and working with you to seek solutions. If you feel that I (or any psychologist) have treated you unfairly or have broken a professional rule, please tell me.

For clients who reside in Nevada: The State of Nevada Board of Psychological Examiners protects consumers of psychological services by regulating the practice of psychology. You may contact the Board of Psychological Examiners online at psyexam.nv.gov, by emailing nbop@govmail.state.nv.us, by calling (775) 688-1268, or writing to the following address:

Board of Psychological Examiners
4600 Kietzke Lane, Bldg B-116
Reno, NV 89502

In my practice as a psychologist, I do not discriminate against clients based on any of the following: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, and it is also required by federal, state, and local laws and regulations. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

## FOR PARENTS OF MINOR CHILDREN

### Legal Custody

It is my policy that all parties with legal custody of a minor (e.g. custodial and non-custodial parents who have legal custody and/or other legal guardians) agree to the minor's participation in psychological services. By signing below you are acknowledging this policy and indicating that you are authorized by all parties to initiate psychological services for your child. If you share legal custody of your child with another guardian and you are not fully authorized to initiate psychological services for your child please notify me immediately and indicate the names of all legal guardians below. I will not proceed with an assessment if all guardians do not agree to allow the child to participate in these services as any guardian may request that the child discontinue services at any time and as not completing an assessment is problematic. I also highly encourage all guardians to attend the initial parent interview so that they may contribute their perspectives regarding the child's developmental history and presenting concerns. If all guardians do not attend the initial interview, any future requests to revise or amend the medical record due to lack of parental input will incur appropriate hourly fees as outlined for email/telephone consultation services. By signing below, you indicate that you understand these policies and have legal custody of the child named below and the right to seek an assessment for that child.

### Court Testimony and Your Minor Child

In custody proceedings, a judge may order a psychologist's testimony if the judge determines that the issues demand it. As your child's psychologist, it is my duty to provide your child with the best care possible. If I am required to provide records or testimony to the court, this may contribute to a "dual-role relationship" between myself and your child. This means that I am serving in conflicting roles (e.g. parent's witness and child's psychologist) and that these roles can have a negative impact on the client, your child, for multiple reasons including potential violations of therapeutic trust, disclosure of confidential information, and other therapeutic issues. Additionally, releasing certain psychological assessment and treatment records to the court may pose legal and ethical issues. For these reasons, unless pre-arranged before you begin psychological services, I will not provide assessment or treatment records to the court for litigation. If I am required to release records under court order, I reserve the right to terminate psychological services.

### Confidentiality and Your Minor Child

When providing psychological services for children and adolescents, I often work closely with parents and other family members or caretakers. When parents, guardians, or other caretakers are actively involved in psychological services, confidentiality between the identified client and psychologist is essential. However, Nevada law states that parents hold confidentiality rights to/for their children. Despite this legal mandate, confidentiality between your child and her/his psychologist is important aspect of the psychological therapy and assessment, as it allows your child to be open and honest when reporting symptoms and experiences. For this reason, I request that you allow some specific information that your child shares with me to be kept private unless your child opts to share that information. I will provide you with my overall impressions and other relevant information during the feedback session.

Exceptions to confidentiality between myself and your child include, but are not limited to, situations in which I am concerned for your child's safety (e.g., I am concerned that she/he may hurt himself or somebody else; I am concerned that your child is being hurt or abused). Please indicate below your preference regarding your right to access your child's complete psychological record.

## Legal Custody/ Multiple Guardian Signature Page

☐ By checking this box, I indicate that I have sole legal custody of the minor child named below. (Please provide a copy of the court decree or paperwork verifying this information when you submit the rest of the intake packet).

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| | |
|---|---|
| _____ | _____ |
| Client/Child's Name (Printed) | Date of Birth |
| _____ | _____ |
| Parent/Guardian #1 Name (Printed) | Parent/Guardian # 1 Signature / Date |
| _____ | _____ |
| Parent/Guardian #2 Name (Printed) | Parent/Guardian # 2 Signature / Date |
| _____ | _____ |
| Parent/Guardian #3 Name (Printed) | Parent/Guardian #3 Signature / Date |

Names of Any and All Legal Guardians Not Listed Above:

_____ _____

## Confidentiality and Your Minor Child

☐ By checking this box, I/we indicate that that I/we will allow Dr. Davis to maintain confidentiality between her and my/our child of some of the information shared by said child in his/her complete psychological record.

☐ By checking this box, I/we indicate that that I/we are **NOT** allowing Dr. Davis to maintain confidentiality of information shared between her and my/our child.

| | |
|---|---|
| _____ | _____ |
| Client/Child's Name (Printed) | Date of Birth |
| _____ | _____ |
| Parent/Guardian #1 Name (Printed) | Parent/Guardian # 1 Signature / Date |
| _____ | _____ |
| Parent/Guardian #2 Name (Printed) | Parent/Guardian # 2 Signature / Date |
| _____ | _____ |
| Parent/Guardian #3 Name (Printed) | Parent/Guardian #3 Signature / Date |

## PROFESSIONAL FEES, PAYMENT, AND INSRUANCE REIMBURSEMENT

### Fees and Payment

Fees will be discussed and agreed upon prior to our first appointment. You may find my sliding scale fee schedule below and online at drracheldavis.com. Your signature on this form and the Fee Agreement form constitutes your agreement to pay the indicated fees.

All fees may be paid by cash, check or credit card. Checks should be made out to Rachel E. Davis, PhD, PC. Unless otherwise arranged, all payments are due at the beginning of [illegible] appointment [illegible].

If you accrue two unpaid appointments, no further appointments will be scheduled until your balance is paid in full. If your account is delinquent for more than 60 days and arrangements for payment have not been agreed upon, I reserve the right to use a collection agency or other legal means to secure payment. In most collection situations, the only information I release regarding a client's treatment is his or her name, the nature of services provided and the amount due.

The following fee schedule represents my sliding scale as of January [illegible], 201[illegible]:

I look forward to working with you and your child. If you have any questions, please feel free to contact me at (702) 776-8990.

| Gross Annual Household Income (Per last tax return) | Neuropsychological Assessments, all inclusive | | Individual Therapy (12 months to 18 years) per hour | Individual Social Skills Therapy (6-18 years) per hour | Group Social Skills Therapy (when available) **per session** |
|---|---|---|---|---|---|
| | Infant/Children 12 Months – 5 years | Children or Adolescents 6-22 years old | | | |
| $60,000 and higher | **$1600** | **$2100** | **$175** | **$175** | **$75** |
| $48,000-$59,999* | **$1400** | **$1900** | **$150** | **$150** | **$55** |
| $36,000-$47,999* | **$1200** | **$1600** | **$130** | **$130** | **$45** |
| $24,000-$35,999* | **$1000** | **$1300** | **$110** | **$110** | **$35** |
| $23,999 or less | **$800** | **$1000** | **$100** | **$100** | **$30** |

### Insurance Reimbursement

I am not contracted with any private insurance companies, and am thus considered an "out-of-network" for many of my clients. For these clients, I am unable to bill the private insurance provider directly. However, I routinely provide clients with a "Record of Services Provided & Fees Collected" (invoice). Clients may then submit this statement to their insurance company for reimbursement (if the client is entitled to out-of-network benefits). My clients generally report that this arrangement works well for them.

Please note that not all psychological services are covered by all insurance plans. Your insurance provider may only cover a portion of my fees. I strongly encourage you to review your health insurance policy prior to meeting with me in order to determine your mental health benefits. It is your responsibility to verify the specifics of your coverage and to file all claims on your own behalf.

Depending on your financial circumstances and total medical costs for any year, psychological services and the cost of transportation to and from appointments may be tax-deductible expenses. I encourage you to discuss this with a tax advisor.

*Medicare: I am required to inform you that currently I do not provide services through Medicare, regardless of your eligibility for these benefits. You are still able to use my services, but you are responsible for all charges.*

# PRIVATE PAY FEE AGREEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I strongly encourage you to consider my fee schedule carefully prior to your initial appointment. I also encourage you to review your health insurance policy to determine your mental health benefits, any limitations on these benefits, if you are entitled to out-of-network benefits, and any reimbursement rates.

My fee schedule is listed below. CPT Codes are included in order to assist in your communication with your insurance provider. Unless otherwise discussed and agreed upon in writing, you are solely responsible for payment of fees as listed. Payment is due at the beginning of each appointment and may be paid via check or cash.

| CPT Code | Service Provided | Time | Fee |
|---|---|---|---|
| 90791 | Psychiatric Diagnostic Evaluation ("Initial Appointment") | 90-120 Minutes | $175 per hour= $262.50 - $350.00 (see sliding scale) |
| 90837 | Individual Psychotherapy | 60 Minutes | $175.00 (see sliding scale) |
| 90846 | Family Psychotherapy without Patient Present | 60 Minutes | $175.00 (see sliding scale) |
| [illegible] | Evaluations for ages 12 months to 5 years | Varies* | $1600 (see sliding scale) |
| 961[illegible] | Evaluations for ages 6-25 years | Varies* | $2100 |
| | Email and telephone consultation | 10 Minutes | $30 |
| | Missed appointments (no Call/no show) | Time as scheduled | Full Fee |
| | Appointment Cancelled without 24 hours' notice | Time as scheduled | $100 |
| | Insufficient Funds (Returned Check) | N/A | $25 |

Occasionally, clients request additional services such as supplemental reports, attendance at meetings, school visits or conferences, consultation with other providers, or other services not included in weekly psychotherapy or assessment. My fee for such services is $175/hour or equivalent fee structure to that for individual therapy found on the sliding fee schedule.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge **$300/hour** for preparation and attendance at any legal proceeding. Due to the unpredictable time requirements of court proceedings, there is a **four-hour minimum** time commitment for court appearances.

If you have questions or concerns regarding fees, I encourage you to speak with me directly. I am committed to providing need-based financial assistance on a limited basis (i.e., sliding fee schedule). If the financial commitment required for my services exceeds your resources, you may choose to contact your insurance provider for assistance locating an in-network mental health provider. I may be able to provide you with appropriate referrals as well.

## For Parents of Minors

The parent who brings the child is responsible for payment in full at the time of service. If the child attends a session without the parent, payment will need to be sent with the child or provided in advance. In the case of separated or divorced parents, where one parent is court-ordered to pay for services, a copy the court-order in its entirety must be provided before this information can be used. Additionally, in the case of separated or divorced parents where both parents have legal custody, both parents are required to review and sign the Fee Agreement Form and all of the Consent Forms.

# PRIVATE PAY FEE AGREEMENT CONTRACT

**Fee Agreement Summary**

- I hereby acknowledge having received and reviewed the information contained in this document from Rachel E. Davis, PhD. I will have the opportunity to ask questions for clarification during our first appointment and may delay signing this document until that time.

- I understand that my agreed upon fee of _____ is due at the beginning of the first interview appointment, unless other arrangements have been made in advance and documented in writing. All fees may be paid by cash or check. Checks can be made out to Rachel E. Davis, PhD, PC.

- I understand that I am responsible for all fees, even if I expect these charges to be covered by my insurance company or any other third party payer. I understand that I am responsible for submitting all insurance claims on my own behalf.

- I understand that any insufficient funds (NSF) or returned checks may be subject to a $25 fee.

- I understand that I will be charged for missed appointments or appointments canceled with less than □□ hours' notice. I understand that my insurance company will not reimburse me for missed appointments or appointments canceled with insufficient notice. Additionally, I understand that telehealth, phone and email consultation, and document review are not typically covered by insurance, and that I may not be reimbursed for these charges.

- My signature confirms that I will act in accordance with the terms detailed in this document and that I agree to participate in psychological services with this psychologist.

- I understand that Dr. Davis does not provide refunds.

- I understand that any and all unpaid balances may be turned over to a collection agency.

_____ _____
Client/Child's Name (Printed) Date of Birth

_____ _____
Parent/Guardian #1 Name (Printed) Parent/Guardian # 1 Signature / Date

_____ _____
Parent/Guardian #2 Name (Printed) Parent/Guardian # 2 Signature / Date

_____ _____
Parent/Guardian #1 Name (Printed) Parent/Guardian # 1 Signature / Date