PsychoEducational Consultant Group
Licensed School Psychologists

4745 Sutton Park Court, Suite 802
Jacksonville, Florida 32224
(904) 874-6164
www.pecgroup4kids.com

Patrick E. Hughes, Ed.S. *Caren C. Jones, Ed.S.* *Faye M. Nussbaum, Ed.S.* *Laura E. Smith, Ed.S.*

We would like to welcome you and your child to our practice. Our group provides school psychology services to children and adolescents with varying learning styles. We are committed to evaluating your child's unique strengths, while maintaining the highest level of integrity and empathy. Through comprehensive evaluation, we will identify your child's cognitive ability level, and will then make appropriate recommendations.

Prior to the appointment, you may want to talk to your child about the upcoming evaluation. It is recommended that you tell your child that the visit to our office is for us to understand how they learn. We recommend that you avoid using words like "test" or "testing". This can put pressure on a child, and may imply that they will either pass or fail. In addition, there is nothing for your child to study prior to their evaluation. Children are asked to complete activities in which they answer questions, look at pictures, and solve problems or puzzles. Most children enjoy the evaluation process, and leave feeling good about their performance. Please make sure your child has a good night's rest the evening before, and has eaten appropriately the day of the evaluation. If your child wears glasses or a hearing aid, they will need to wear them during their evaluation.

Your family's privacy is of utmost concern to us. You have the right to expect confidentiality regarding your child's evaluation results. The information gathered during the evaluation process is kept confidential, except where required by law. We can communicate with a third party (e.g., staff members at your child's school, their teacher, therapist, or physician) regarding your child and their assessment results, but you must first complete a Release of Information Authorization form. If you need to cancel your child's appointment, we require 24-hours' notice. Clients cancelling with less notice will incur a $50 cancellation charge, unless our staff is in agreement that you were unable to attend due to circumstances beyond your control.

Please remember to bring copies of your child's most recent report card, available standardized test scores, and any psychoeducational reports to the evaluation appointment. In order obtain additional information about our practice, office procedures and policies, or to help you understand the assessment process, please visit our website at www.pecgroup4kids.com. We look forward to working with your family soon. If you require additional information, please do not hesitate to get in touch with us at 874-6164.

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Consent for Individual Evaluation Services

Our practice consists of licensed and certified school psychologists who are qualified to conduct thorough psychoeducational evaluations. These evaluations can include an assessment of: intellectual ability, academic skills, cognitive processing ability, adaptive skills, concerns with inattention/hyperactivity/impulsivity, social-emotional concerns, and Autism Spectrum. Through in-depth evaluation, we are able to identify your child's learning strengths and weaknesses, and we will generate recommendations to address psychological and/or educational needs. In addition, we can provide professional consultation services with regard to appropriate educational interventions and planning if needed.

Child's Name: ____

Date of Birth: ________________

I give my permission for the PsychoEducational Consultant Group to complete this assessment with my child.

Parent/Guardian Signature: ______________________________ Date: __________

Please initial the following:

________ I have received a copy of the PsychoEducational Consultant Group's *Notice of Our Policies and Practices to Protect the Privacy of Your Health Information - Health Insurance Portability and Accountability Act (HIPAA).*

Payment is due at the time of service. We accept cash, checks, or credit cards. Checks should be made payable to: PsychoEducational Consultant Group. **A $50 cancellation fee will be charged for all appointments cancelled with less than 24-hours' notice.** We do not file insurance claims for direct payment. However, we can provide you with a receipt for our services that you may submit along with a request for insurance reimbursement. Please contact your insurance provider to learn what documentation and prior approval may be needed. Results and recommendations from your evaluation will be provided to you in the form of a comprehensive report. We will schedule a feedback session to discuss the results of your evaluation at our office or by phone. Our goal is to ensure that the information is clear and helpful for you. We will address any questions or concerns you may have at that time. Information obtained from you or through your assessment will not be released without your explicit written permission to do so. We look forward to working with your child.

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Acknowledgement of Available Services

Student: ______________________________ Date of Birth: ______________
School: ______________________________ Grade: ______________
Parent/Guardian: ____

Evaluating school psychologist: _______ Patrick E. Hughes, Ed.S., Licensed School Psychologist (SS 873)

_______ Faye M. Nussbaum, Ed.S., Licensed School Psychologist (SS 874)

_______ Laura E. Smith, Ed.S., Licensed School Psychologist (SS 955)

As the parent/guardian of the above named student, I am requesting a private intellectual or psychoeducational evaluation to be performed at my own expense. I am fully aware that some or all of the requested services may be available to me at no cost through the public school system. I am aware that the evaluating school psychologist is a Dual Practitioner (a school psychologist who works both in the public school system and the private sector). As such, he/she may not serve as an independent evaluator in any proceedings brought by me against the public school system in which the licensed school psychologist is employed.

I understand that I must give my written permission in order for the evaluating school psychologist to receive and/or release pertinent psychoeducational, psychosocial, and medical data to or from my child's school. I also understand that a number of factors need to be considered in order for any evaluation to lead to appropriate educational programming within the school system. Such factors may include, but may not be limited to, the following:

- While a school district must consider the results of a private evaluation, they are not required to accept the results and recommendations for eligibility decisions.
- The school system will need to collect additional data as part of the comprehensive evaluation process.
- The results of certain tests may not be valid if re-testing occurs more frequently than recommended by test publishers.
- In order for tests to be utilized for eligibility determination, selected test instruments must be consistent with the local school district's procedures.

______________________________ ______________________________
Parent/Guardian Signature Date

______________________________ ______________________________
Licensed School Psychologist's Signature DOE Certificate Number/License Number

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General Information and History

Today's Date: ______________________ **Completed By:** ______________________

Child's Name: ____

Date of Birth: ________________ **Age:** __________ **Grade:** ________________

School: ______________________ **Teacher:** ______________________

Home Address: ____

City: ______________ **State:** __________ **Zip:** ________ **County:** ________

Home Phone: ____________________ **Cell Phone:** ____________________

Mother's Name: ____________________ **Mother's DL #:** ____________________

Father's Name: ____________________ **Father's DL#:** ____________________

Child lives with: ____ Both Parents ____ Mother ____ Father ____ Other: ________________

Other family members in the home (e.g. step-family members, siblings, or grandparents) :

Name: ________________________ Relationship: ________________________

Name: ________________________ Relationship: ________________________

Name: ________________________ Relationship: ________________________

1. Has your child ever had hearing/ear problems (e.g., frequent infections/tubes)? If yes, please indicate below:

____

2. Has your child ever had vision/eye problems (e.g., glasses or blurred vision)? If yes, please indicate below:

____

3. Is your child currently taking any medication? If yes, please indicate below:

____

4. Has your child had any illnesses other than the usual childhood diseases? If yes, please indicate below:

____

____

5. Does your child show signs of having behavior, emotional or other similar problems? If yes, please explain below:

____

____

6. Have there been any changes in your family situation or traumatic events in the past year? (e.g. divorce, family death, remarriage, or absence of parent) Please explain below:

____

____

Please describe your child's strengths:

____

____

____

____

Please describe any special concerns that you may have about your child:

____

____

____

____

Does your child participate in any sports or extracurricular activities? If yes, please describe:

____

____

____

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Authorization to Leave Personal Health Information (PHI) by Alternate Means

The PsychoEducational Consultant Group strives to ensure that confidentiality regarding our client's Personal Health Information (PHI) is maintained at all times. Due to the confidential nature of psychoeducational consultations, evaluations, written reports, test results, etc., we require your written permission to communicate with you if we are unable to reach you by phone. Please complete the following information and indicate your preferences.

Please initial and fill in appropriate phone number or email address for all that apply:

	Phone number/e-mail address	Initials
May leave detailed message on voicemail at home phone #	________________	________
May leave detailed message on voicemail at work phone #	________________	________
May leave detailed message on voicemail for cell phone #	________________	________
May correspond via e-mail	________________	________
May send evaluation results/report via e-mail	________________	________

With my signature below, I acknowledge and understand that this information will be kept in the client's records, and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify the PsychoEducational Consultant Group should I change one or more of the telephone numbers or e-mail addresses listed above. I also understand that I have the right to refuse to sign this authorization, and the client's evaluation will not be affected by my refusal to sign.

____ ________________
Parent/Guardian Signature Date

I **DO NOT** give permission for the PsychoEducational Consultant Group to leave a detailed message on voicemail or send information via e-mail.

____ ________________
Parent/Guardian Signature Date

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Release of Information Authorization

I hereby authorize members of the PsychoEducational Consultant Group to:

_______ Obtain _______ Release _______ Exchange

any and all information regarding ____________________ that is deemed necessary for completing an appropriate psychoeducational evaluation. Those records may include previous psychological or psychiatric reports, medical records, educational evaluations, social or developmental information, or school records. I understand that the obtained information will be used in making an accurate assessment of the above named client's abilities and needs. The confidentiality of the obtained information will be strictly maintained and will be used only in the best interest of the client.

Records request to/from: ____

____

____

This release is valid for one year, and may be revoked by the client at any time.

Signature ____

Relationship to Client ____

Date Signed ____

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Notice of Our Policies and Practices to Protect the Privacy of Your Health Information Health Insurance Portability and Accountability Act (HIPAA)

We strive to keep your information private according to the guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how a client's psychoeducational information may be used and disclosed, and how he/she can gain access to this information. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *"You"* and *"your"* refer to the client. In the case the client is a minor, references to psychoeducational and medical information relate to the minor and references to accessing this information relate to the parent/legal guardian.
- *"PHI"* refers to information in your health record that could identify you.
- *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist/school psychologist.
- *Payment* is when we obtain compensation for your healthcare. At this time, health insurance is not accepted. Parents/legal guardians are responsible for full payment for services.
- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities; business-related matters such as audits and administrative services; and case management and care coordination.
- "*Use*" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

- We may use or disclose *PHI* for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.
- We would also need to obtain an authorization before releasing your therapy notes. *"Therapy notes"* are notes we have made about our conversation(s) during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than *PHI*.
- You may revoke all such authorizations (of *PHI* or therapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1) we have relied on that authorization or 2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose *PHI* without your consent or authorization in the following circumstances:

- **Child Abuse:** If we know, or have reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that we report such knowledge or suspicion to the Florida Department of Child and Family Services.

- **Adults and Domestic Abuse:** If we know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight:** If a complaint is filed against us with the Florida Department of Health on behalf of the Board of School Psychology, the Department has the authority to subpoena confidential mental health information from us relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law. We will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform us that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, we must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and School Psychologist's Duties

Patient's Rights

- *Right to Request Restrictions*

  You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*

  You have the right to request and receive confidential communications of *PHI* by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy*

  You have the right to inspect or obtain a copy (or both) of *PHI* in our mental health and billing records used to make decisions about you for as long as the *PHI* is maintained in the record. Upon your request, we will discuss with you the details of the request process.

- *Right to Amend*

  You have the right to request an amendment of *PHI* for as long as the *PHI* is maintained in the record. We may deny your request. Upon your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting*

  You generally have the right to receive an accounting of disclosures of *PHI* regarding you. Upon your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy*

  You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

School Psychologist's Duties

- We are required by law to maintain the privacy of *PHI* and to provide you with a notice of our legal duties and privacy practices with respect to *PHI*.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will notify you by mail.

V. Questions and Complaints

- If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact us at (904) 874-6164.

- If you believe that your privacy rights have been violated and wish to file a complaint with us, you may send your written complaint to 4745 Sutton Park Court, Suite 802, Jacksonville, Florida 32224.

- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

- You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

- This notice will go into effect today.

- We reserve the right to change the terms of this notice and to make the new notice provisions effective for all *PHI* that we maintain.