STRATEGIC EVALUATIONS

Mary Beth Selner O'Hagan, PhD & Mary Stall, PsyD

Client Information Form

(Assessment)

Student's Full Name: _____

Date of Birth: _____

School Attended: _____

Parent #1: _____ Phone: _____

Parent #2: _____ Phone: _____

5290 East Yale Circle Suite 207 · Denver, CO 80222
303-758-0744 · strategicevaluations@gmail.com

INFORMATION, DISCLOSURE, AND CONSENT

The following information is provided to you in compliance with Colorado State Law. In addition, this information is important in assuring that you are aware of your rights as a client and of the legal, ethical, and practical issues regarding the practice of psychological evaluation and intervention.

Credentials:

Dr. Mary Stall is a licensed psychologist in the state of Colorado, License number #2799. Her educational background includes the following degrees:

- B.A. in Philosophy, Louisiana State University, 1986
- M.A. in English and Creative Writing, University of Texas at Austin, 1989
- M.A. in Clinical Psychology, University of Denver, 2000
- Psy.D. in Clinical Psychology, University of Denver, 2002

Dr. Stall completed her internship in Clinical Psychology in August 2002 at the University of Denver Counseling and Behavioral Health Center and her post-doctoral supervision hours in private practice and at The Children's Hospital of Denver.

Dr. Mary Beth O'Hagan is a licensed psychologist in the state of Colorado, License number #2045. Her educational background includes the following degrees:

- B.A. in Psychology and Computer Applications Program, University of Notre Dame, 1987
- M.A. in Clinical Psychology, University of Iowa, 1990
- Ph.D. Clinical Psychology, University of Iowa, 1992

Dr. O'Hagan completed her internship at the Jewish Board of Children and Family Services in New York City, and her post-doctoral supervision hours in Dr. Daniel Kindlon's private practice.

The practice of licensed or registered persons in the field of psychois regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-2291.

A licensed psychologist must hold a doctoral degree in psychology, have one year of post-doctoral supervision, and pass state licensing requirements. If you would like information regarding the regulatory requirements of other mental health professionals, please let me know, and I will provide that information to you.

Client Rights:

You are entitled to receive information about our assessment methods, the tests we use, the estimated timeline for your assessment, and our professional fees.

- You are free to seek a second opinion from another mental health professional or to terminate assessment at any time.
- In a professional relationship, such as ours, sexual intimacy between a therapist and a client is never appropriate. Such a violation should be reported to the State Grievance Board. The Colorado Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of licensed and unlicensed psychotherapy practitioners. The State Grievance Board is a part of this system. You may contact the State Grievance Board at 1560 Broadway, Suite 1340, Denver, Colorado 80202, or phone 303-894-7766.

Generally speaking, the information provided by a client during assessment is legally confidential. A **written release** from you is required in order for us to release or obtain any information. However, there are important exceptions to this general rule of confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218) and include criminal or delinquency proceedings, serious danger to self or others, grave disability, and instances of child or elder abuse.

Finally, within the mental health field, consulting with qualified clinicians is considered a "best practice" approach. We may share information without identifying details with licensed clinicians with whom we consult in the interest of providing high quality treatment and assessment. These professionals are also legally bound to keep all information confidential.

Business Practices:

Fee Information/Billing Practices
Our fee for full psychoeducational assessments ranges from $2700 to $3000, depending on age and the extent of the testing needed. Please see the final page of this packet for your specific cost. The standard fee for additional consultation is $150 per hour. There will be a $25 charge for all checks returned due to insufficient funds.

Cancelled/Missed Appointments
If you are unable to keep a scheduled appointment, please notify us as soon as possible.

Phone Calls
If you need to speak with us between scheduled appointments, please leave us a voicemail, and we will return your call as soon as possible. Once the evaluation is complete, subsequent phone calls may be charged at our hourly rate.

Electronic Communication
Please be advised that email is not a secure method of private communication. As such, sending confidential information or discussing clinical information via email is not advised. Email is also not an appropriate method of contacting us in an emergency situation (please see emergency contact procedures below). Email may be used to contact us regarding scheduling issues and other administrative and non-clinical issues.

Emergency Procedures
If you are experiencing a clinical emergency, please follow the emergency contact procedure outlined in our voicemail message, and we will return your call as soon as possible. Please reserve this procedure for true emergencies. In a life-threatening emergency or if you cannot wait for our return call, please call 911 or go the nearest emergency department.

Consent and Agreement for Psycho-Educational Testing and Evaluation:

I, _____, agree to allow Mary Stall, PsyD and Mary Beth O'Hagan PhD to perform the following services:

___ Psychological assessment
___ Report writing
___ Consultation with school personnel
___ Consultation with medical health providers
___ Consultation with tutors, coaches, and other academic support providers
___ Other (describe):

I understand that these services include direct, face-to-face contact, interviewing, or testing. They may also include the psychologists' time required for the reading of records, consultations with other professionals, scoring of tests, interpretation of results, writing reports, and any other activities to support these services. If I have questions or concerns about this assessment, the evaluators agree to be available to discuss them after completion of the testing and interviews. I understand that this evaluation is for educational and treatment planning purposes.

I also understand that Drs. Stall and O'Hagan agree to the following:

- The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations, and with the applicable state and federal laws.
- Tests will be chosen that are suitable for the purposes described above. 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.
- Tests and test results will be kept in a secure place to maintain their confidentiality. Please note that records will be shredded seven years after completion of an evaluation or, in the case of a minor client, seven years after that client reaches 18-years-old (i.e. at age 25).

I have read the preceding information and been advised verbally of my rights and responsibilities as a client. I understand my rights as a client, as the client's responsible party, or as the parent of a minor child, and agree to the information contained in this document. A copy of this information has been given to me for my records.

I agree to help as much as possible, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

_____
Client or Responsible Party's Name (please print)

_____ _____
Client or Responsible Party's Signature Date

_____ _____
Mary Stall PsyD Date

_____ _____
Mary Beth O'Hagan PhD Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE

This document contains information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides privacy protections and client rights with regard to the use and disclosure of your protected health information for the purposes of treatment, payment, and health care operations. If you have any questions about the information contained in this document, please ask and we will be happy to answer them for you.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION (INCLUDING MENTAL HEALTH INFORMATION) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our clients' confidentiality and only release information in accordance with state and federal laws and the ethics of the psychology profession. This notice describes our policies related to the use and disclosure of clients' health information.

Use and Disclosure of Protected Health Information

Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. We use and disclose the minimum necessary health information about you for these purposes, as allowed by state and federal law.

1.) Treatment: We may use and disclose health information to provide, manage, and/or coordinate care and to consult with other professionals. For example, we may share relevant information to facilitate appropriate emergency coverage by another professional in our absence.

2.) Payment: We may use and disclose your health information to obtain payment for services that we provide to you. For example, we may share information to verify insurance and coverage and to process claims and collect fees.

3.) Healthcare Operations: We may use and disclose your health information as part of our internal healthcare operations. For example, we may share information for the purpose of reviewing treatment procedures and records to assure quality, for training purposes, and for licensing and/or business activities.

Other Uses and Information Disclosed Without Your Consent

In compliance with state and federal law, the following information may be disclosed without your consent:

1.) Mandated Reporting: We may disclose health information about you related to the suspicion of child and/or elder neglect and/or abuse.

2.) Emergencies: In emergency situations, we may disclose health information to prevent serious harm and/or death to yourself or others.

3.) Criminal Activity and/or Danger to Others: We may disclose health information if a crime is committed on premises or against any personnel/staff, or if we believe there is someone who is in immediate danger.

4.) Appointment Scheduling/Client Contact: We may use information you provide to contact you, to schedule, or remind you of appointments, or to discuss treatment services.

5.) National Security, Intelligence Activities, and Protective Services to the President and Others: We may disclose health information to authorized federal officers as authorized by law in order to protect the President or other national figures, or in cases of national security.

6.) Judicial and Administrative Proceedings: We may disclose your health information in the course of judicial or administrative proceedings in response to a valid court order or other lawful process.

Client Rights

1.) Right to Inspect and Copy: You have a right to look at or get copies of your health information, with limited exceptions (i.e., testing protocols). Your request must be made in writing. If you request a copy of your record, a reasonable charge may be made for costs incurred.

2.) Right to Amend: You have the right to request that we amend your health information. Your request must be made in writing, and it must explain why the information should be amended. We have the right to deny your request if we believe the information contained in your record to be accurate and complete. If denied, you have the right to file a disagreement statement.

3.) Right to Accounting Disclosures: You have the right to receive a list of instances in which your health information has been disclosed for purposes other than treatment, payment, or healthcare operations. This accounting does not include disclosures made to you or disclosures pursuant to a signed authorization to release information.

4.) Right to Request Restrictions: You have a right to request a restriction or limitation on the health information used or disclosed about you. For example, you may request that information not be disclosed to an insurance carrier, in which case you would be responsible for payment in full for services provided. Your request must be made in writing. While we are not obligated to agree to your request, we will consider the request very seriously. If we agree to the restriction/limitation, we will abide by our agreement unless the information is needed in an emergency or required by law (for examples, please see the section above entitled, **Other Uses and Information Disclosed Without Your Consent**).

5.) Right to Request Confidential Communications: You have the right to request that we contact you regarding health matters in a certain way or at a certain location. For example, you may request that we only contact you through your cell phone number, or only at work. We will make every attempt to accommodate reasonable requests.

6.) Right to Obtain a Paper Copy of this Notice/Changes in Notice: You have the right to receive a paper copy of this notice and any amended notice. We reserve the right to change our privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, we will make a new notice available to you at our place of practice.

7.) Right to Release your Health Information: You have the right to request that certain health information be released at your request by signing an authorization to release information. You may revoke a written authorization for release of information at any time; this request must be made in writing, and will be effective only for disclosures that have not already been completed.

8.) Right to Complain: If you believe your privacy rights have been violated, you have the right to file a complaint with us, or you may file a complaint with the United States Department of Health and Human Services. No retaliation will be made against you if you choose to file a complaint.

I understand and agree to all of the above information. A copy of this information has been given to me for my records.

_____

Client or Responsible Party's Name (please print)

_____ _____

Client or Responsible Party's Signature Date

_____ _____

Mary Stall, PsyD Date

_____ _____

Mary Beth O'Hagan PhD Date

Fee Agreement

I understand that the fee for this assessment will be: $3000. This fee includes the intake, assessment, and feedback sessions, as well as the written report.

I understand that a deposit of one half of the base fee is due 2 weeks ahead of the first appointment (parent intake) and the second half is due at the parent intake, unless other arrangements are made. If additional fees are incurred due to the complexity of the assessment, parents will be billed accordingly, at or following the feedback. If this situation applies, we will discuss this with you at the parent intake.

I understand that if additional time is needed following the feedback, I will be charged at the rate of $150/hour. This includes meetings, as well as phone consultations, and responding to email requests. Any phone consultation (with parents, teachers, therapists, tutors, or others) will be billed at increments of the hourly rate (i.e. you will be billed $75 for a 30-minute phone consultation). I understand that time will be accrued in 15-minute increments and billed at least monthly.

_____

Client or Minor Child's Name (please print)

_____

Client or Responsible Party's Name (please print)

_____ _____

Client or Responsible Party's Signature Date

_____ _____

Mary Stall, PsyD Date

_____ _____

Mary Beth O'Hagan PhD Date

** Additional fees may be charged for older students who have not been tested and diagnosed previous to eighth grade. Additional cost is incurred in these cases due to the extra time demands of (1) gathering historical information and reviewing records, (2) consultation with relevant parties, and (3) documenting the history of the diagnoses. Typically, this can add 1 to 6 hours of clinical time, charged at a rate of $150/hour.*