I understand that I am undergoing a psychological evaluation to determine if treatment is necessary or advisable. I hereby authorize and consent to the administration of all diagnostic procedures and assessment measures that are part of this evaluation. I understand that after review of this evaluation and testing results, therapeutic treatments may be recommended or considered necessary by the judgment of the psychologist/therapist, including counseling, psychotherapy, traditional biofeedback (hand temperature, GSR—sweat, EMG—muscle tension, etc.), EEG biofeedback (neurofeedback for healthy brainwaves), and Interactive Metronome® Training (IM). I understand that I have the right to be informed of the various steps and activities involved in receiving these services. I understand that I have the right to make an informed decision whether to accept or refuse treatment. I understand that I may revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent.

I understand that I have the right to humane care and protection from harm, abuse, or neglect. I also understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults. I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others (e.g. potential for suicide or homicide).

I understand that there is no assurance and no representation that any individual, including myself, will improve from treatment. Because psychotherapy and biofeedback are cooperative efforts between the client and his/her therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand that treatment involves the learning of new skills and a consistent investment of time, effort, and practice. I understand that clients see the best results and improvements, including maintenance of these changes, when learning is practiced and reinforced frequently, especially in the beginning stages of treatment. Therefore, I understand that, in order to maximize the effectiveness of training, CEPD often recommends at least two sessions per week. Moreover, I understand that I should make efforts to make and keep appointments and to be consistently ready and motivated. I further understand that homework, such as practicing relaxation methods (deep breathing, relaxation tapes, hand temperature monitoring, etc.) is integral to the treatment process and should be practiced frequently and regularly. I understand that during the course of my treatment, material may be discussed that may be upsetting in nature and that this may be necessary to facilitate treatment. I understand that it is my responsibility to monitor the subjective effects of training and to continue treatment so long as benefit is perceived. I understand that different individuals progress with treatment at different rates and with different styles and that the research literature indicates that there are some individuals who are apparently unaffected by treatment. Accordingly, I understand that I am encouraged to evaluate progress after about ten sessions to determine if further treatment is indicated. Furthermore, I understand that communication with my psychologist/therapist is invited and strongly encouraged at this point or at any time during the treatment process. Furthermore, if I am considering or planning to terminate treatment, I am encouraged to discuss the factors contributing to my concern or decision. I understand that my feedback is essential for promoting and ensuring the quality of care and service that I deserve. I understand that if my condition deteriorates or other difficulties arise that are beyond the competency and training
experience or resources of providers at CEPD, my therapist will work with me to find a more appropriate therapist or may refer me for psychiatric consultation.

I understand that some individuals have reported that biofeedback training may affect one’s response to medication. I understand that I should not stop or alter any of my medications without consulting my physician/psychiatrist. I understand that I should continue ongoing therapies until otherwise advised by my physician. Should new symptoms develop, it is my responsibility to inform my health care providers including my therapist with CEPD. I further understand that the therapists at CEPD are not medical doctors and cannot prescribe medication or change dosage levels for any of my conditions.

I understand that the therapists are either licensed practitioners or working under the supervision of licensed practitioners in compliance with licensure laws.

I understand that in an attempt to better serve the community and its clients, CEPD conducts research of treatment interventions and their effectiveness through client self-report measures. New clients are asked to voluntarily fill out questionnaires at each visit to identify changes in behavior. All results are coded to maintain confidentiality. The Clinical Director will conduct each review and address any concerns or questions.

FOR CLIENTS SEEKING/CONSIDERING EEG BIOFEEDBACK TRAINING

I understand that EEG biofeedback is used for a variety of conditions that appear to be associated with irregular brain activity, including, but not limited to, hyperactivity, attention deficit disorder, specific learning disabilities, conduct problems, sleep disorders, depression, anxiety, chronic pain, minor head injury, and seizure disorders. I understand that training is recommended on the basis of empirical observation of improvement in clients with similar conditions. I understand that EEG biofeedback training requires placement of surface electrodes on my scalp for the purpose of recording my EEG (brainwave activity) and the use of this signal to provide video displays and audio signals. I understand that the training is noninvasive and appears to be a harmless procedure as far as is known at present, and no injuries are known or reported in the EEG biofeedback literature. I understand that there is some indication that in a few clients, improvement may fall off after the cessation of training, and that these individuals would benefit from periodic follow-up or booster sessions.

Psychological Assessment Measures

At the beginning of treatment at our office we typically administer psychological assessment measures. Clients and for those under 18, his/her parents, will be given a battery of standardized psychological assessment measures to help us acquire a better understanding of the intensity of symptoms and degree to which they are impacting quality of life. As first identified by the American Psychological Association (APA), standardized assessment is necessary to determine the extent that cognitive, behavioral and or emotional problems are impacting activities of daily living and psychological and emotional well-being. Psychological standardized assessment enables us to measure a large number of personalities, cognitive and neuropsychological characteristics simultaneously and, as a result, cover a wide range of functional domains. In other words, psychological assessment allows us to get a clearer sense of the degree and scope of a person’s need for treatment. Many assessment measures are questionnaires or surveys that require completers to rate clients on various scales (multiple choice-“Always, Often, Sometimes, Never”; True/False, etc.) or to check symptoms/issues that
are of current or past concern. Many of these forms include questions about what are often referred to as the ABC’s of psychology: Affect (feelings), Behavior, and Cognitions (thoughts). Other assessments might ask questions about knowledge a client has or might require a client to perform simple tasks like counting, arranging blocks or drawing pictures.

Standardized psychological assessment is a vital tool that enables us to modify, validate and strengthen impressions of a client’s difficulties, which were formed during the initial psychodiagnostic interview. Often a person’s diagnosis and treatment goals are unclear after the initial session. We may want to rule out competing diagnoses or confirm clinical impressions. Often the information from an initial session is inconsistent. For example, often parent reports conflict with each other or with the report of a child/adolescent client. Similarly a client may indicate that he/she is not depressed but cries throughout most of the interview. Moreover, many clients/parents have difficulty verbally expressing their thoughts/feelings during a session interview or might forget to mention specific information.

Having a clear diagnosis is important because different diagnoses require different treatment interventions or modalities in order to realize successful treatment outcomes. The results of standardized assessment can enable us to target specific symptoms for treatment, clearly identify therapeutic needs and to highlight and fine tune empirically supported therapy (EST) strategies that target a client’s identified problems and issues. A standardized baseline of emotional, physical and mental distress through psychological assessment is also appropriate to help gauge progress in treatment. We believe that gauging the progress of therapy is particularly important for short-term therapy in order to make the treatment and outcome more efficacious.

**Update Psychological Assessment Measures**

When determined to be medically necessary, for both children/adolescents and adults, updated assessments are conducted approximately every 4-6 months. Clients/parents/guardians generally will be responsible for co-pays/fees due for assessments. The purpose of assessments is to compare results with initial assessments, determine progress and fine-tune treatment plans. Updated assessments will be reviewed in a parent/client review meeting (regularly scheduled session or specially scheduled session). Generally, updated assessments are conducted for one or more of the following reasons:

- To evaluate consistency of reports among parent/other observations and client self-report
- To evaluate congruence among client self-report and objective findings
- To fine-tune treatment plan based on results of assessments
- To measure the efficacy or usefulness of therapy and to determine progress in treatment compared to initial or previous evaluations
- The client suffered a set-back or regression due to new stressors

**Confidentiality**

I understand that records and information collected about me will be kept in utmost confidentiality according to Federal and State law and professional and ethical guidelines, except in cases mandated by law. However, I understand that use and disclosure of my protected health information (PHI) will be limited to the minimum necessary for Treatment, Payment, and Operations. Furthermore, I have received, read, understand, and consent to the general guidelines outlined in CEPD Management Services, Inc.’s Notice of Policies and Practices To Protect The Privacy of Your Health Information (effective date April 14, 2003). I understand that all information will be revealed only on an as needed basis and will be held in utmost confidentiality.
I understand that there may be publication and/or other educational uses (such as case studies for a particular disorder included) of the data collected during my treatment. I understand that any identifying information will be deleted and that no information that identifies me will be released without my separate consent, except as specifically required by law.

**Scheduling and Cancellation Policies**

We make every effort to meet all of our clients’ scheduling needs. However, we recommend that in order to reserve times, especially for high demand after school or evening appointments, clients schedule appointments for at least one month in advance (preferably two). Clients will be called by our office two to one day before appointments to confirm. Since our office is a busy private practice, last minute cancellations place clients who are waiting for an appointment at a disadvantage. If appointments are canceled or rescheduled in a timelier manner, we can help to ensure more effective treatment for all of our clients.

**CANCELLATION POLICY CHANGE EFFECTIVE MAY 19, 2015**

Clients who cancel with less than 24 hours notice or who “No Show”: **WILL BE CHARGED A $50.00 LATE CANCELLATION FEE** for the FIRST and EVERY L24 cancellation or No Show. Warnings will no longer be issued for first time L24 cancellations and the fee will be reduced/and or waived only in extraordinary circumstances.

This fee is significantly less than the charge for an entire session. Most practices charge the full amount of the missed session, sometimes $200 or more. Similarly, many practices require 48, even 72 hours, notice for cancellations. Your insurance will not cover this charge. Clients will be billed and are wholly responsible for these charges. Payment will be collected along with the usual fees/co-pay at client’s next session. Except for in rare cases, providing documentation or rescheduling of cancelled appointments does not result in reducing/waiving of the L24 cancellation fee.

**Fees for Services Provided by CEPD Management Services, Inc.**

**Psychotherapy Services**

I understand that the majority of clients have medical/psychological insurance that covers some or all of the fees for psychological services. I understand that CEPD Management Services, Inc. will work with me to determine the extent of my insurance coverage, including deductibles, co-pays, and the balances for services provided that I am responsible for paying. I understand that CEPD Management Services, Inc. is an in-network or preferred provider for several insurance plans and, consequently, is obligated to charge the accepted usual and customary fee of the insurance plan. I further understand that CEPD participation in networks or designation as a preferred provider may be subject to change at anytime. Similarly, usual and customary fees of insurance plans are subject to change.

I understand that if I do not have the financial resources to pay the full fee or full co-payment, my situation may be evaluated by CEPD and I may be charged for services on a sliding fee scale.
Other Services

I understand that I may be provided other services or other fees may be incurred as a result of my treatment at CEPD Management Services, Inc. and that these services are NOT covered by my insurance carrier.

Consultation Fee (including phone sessions, phone consultations with client, parent, other healthcare provider, school personnel)
- I understand that contact with my therapist or other provider of CEPD Management Services, Inc., in between scheduled appointments will depend upon therapist availability, except in emergencies. I further understand that phone consultations with me or another on by behalf (i.e. consultation with school personnel, other provider such as my primary care physician or psychiatrist, parent, etc.) or other contact with therapist exceeding 5 minutes duration will be billed a consultation fee according to the fees below. I understand that my insurance carrier will NOT cover this charge and that I am responsible for full payment of these charges before my next scheduled appointment. I understand that if consultation is off-site, for example a school meeting, travel time of my therapist or other provider will be included in the fee calculation.
  - 6 – 20 minute consultation $30.00
  - 20 - 30 minute consultation $75.00
  - 31 - 45 minute consultation $100.00
  - 45 – 60 minute consultation $150.00
  - 61 -90 minute consultation $200.00
  - 91 – 120 minute consultation $250.00

Copy of Records (released to client/parent/guardian) $25.00

Written Reports
- I understand that written reports (summarizing psychodiagnostic evaluations, treatment recommendations/plans, treatment progress, Educational (IEP/504 plan) recommendations or reports justifying such), requested by me are NOT included as part of the evaluation or treatment process. Written reports will incur a fee of $150.00 for reports 3 pages or less and an additional charge of $25.00 for each additional page. I understand that my insurance carrier typically will NOT cover these charges and that I am responsible for full payment. I understand that signed reports will be released only when payment of the report is made in full.

Returned Check Fee $40.00

Delayed Payment Administration Fee $5.00
- Full Co-pays/Fees for sessions are due at the time of the appointment. Effective February 1, 2010 clients who do not pay their full fee due at the time of their appointment will incur a $5.00 Delayed Payment Fee. This fee will also apply to L24 cancellation fees that are not paid in full at the time of the next scheduled appointment. This administration fee will also apply when clients request bills/invoices (e.g. third-party is paying for treatment—see below). If fees due are not clearly established at the time of service (conflicting benefit information, waiting for insurance claims processing) the fee will not apply. However, once fees are established, payment is due within 15 days and the $5.00 Delayed Payment Fee will be applied for every 30 days that the fees are past due. If payment is delinquent by 90 days or more, CEPD Management Services, reserves the right to refer such outstanding debts to a collection agency.
Bills or Invoices Requested by Client $5.00

- I understand that a $5.00 fee will be incurred for the creation of statements of payments made that do not include receipts for payments made in the normal course of business.

For example, some clients request statements of fees paid for tax/accounting purposes or to submit for reimbursement by healthcare flexible spending accounts or other third party payors (parents, trust fund, etc.). I understand that these statements will incur the $5.00 statement fee.

By signing this form, I indicate my understanding of the principles and policies set forth here in this Informed Consent Document (3 pages in length) and waive any claim of damages due to treatment including worsening of my condition for which the treatment was undertaken, claimed side effects, or the failure to improve with training/treatment. I agree to submit any dispute with CEPD Management Services, Inc. to binding arbitration under the rules of the American Arbitration Association. I understand that an electronic copy of this authorization and consent shall be considered as effective and valid as the original.

I have read this document in its entirety and have had the opportunity to have my questions answered to my satisfaction. I understand and fully agree to abide with all of the above policies and statements. I have received a copy of this policy.

Client/Patient Name (Printed) ________________________________________________________________

_____________________________________________________________________________________
Signature of Patient/Client                                      Date

_____________________________________________________________________________________
Signature of Parent, guardian, or authorized representative (When required)                                      Date

_____________________________________________________________________________________
Signature of Insurance Policy holder                                      Date

_____________________________________________________________________________________
Signature of Witness (CEPD Employee)                                      Date

CEPD Management Services, Inc.
I have read and received a copy of CEPD Management Services, Inc.’s Notice of Privacy Practices.

This constitutes a receipt of the Notice of Privacy Practices written acknowledgement form.

____________________________________________________________
Signature of client/parent               Date

**OPT-OUT of Contact by CEPD via Constant Contact Emails**

My signature below indicates that I prefer to opt-out of receiving emails via Constant Contact or directly by CEPD or its staff members regarding articles/topics of interest, new services, or similar information.

____________________________________________________________
Signature of client/parent               Date
CEPD Management Services, Inc.

ASSIGNMENT OF RIGHTS/BENEFITS AND
INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name:

__________________________________________________________________________________________

I hereby authorize the release of the minimum necessary protected health information to process insurance claims for mental health services provided to me or my dependent by the mental health professionals of CEPD Management Services, Inc.

I hereby authorize payment of any applicable benefits directly to CEPD Management Services, Inc. for such allowable professional services as may be provided me or my dependent according to my current insurance policy. This document is to be deemed an assignment of all of my rights with regard to First Party Benefits under any policy which I would have a legal claim for benefits. I also authorize the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due should such sums not be paid within the legally prescribed period of time.

I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred by the above named patient, and I agree that I am financially responsible to make payment in full on remaining patient balances as allowed by law should my insurance carrier determine that the services I or my dependent received are not covered.

I understand that I have the right to confirm the mental health benefit information that was quoted to CEPD Management Services, Inc. by my insurance company.

If for any reason you (the applicable insurance carrier) refuse to accept this form of assignment, please notify me in writing within (10) days as to the reasonable basis for not accepting the assignment, under what circumstances I can assign benefits and what reasonable restrictions if any are being placed on my right to assign benefits, so that I may take the appropriate action. If I do not hear back from you within the (10) days, I will presume that this assignment has been accepted. Additionally, both, the above referenced provider and I will detrimentally rely on any payment made directly to the provider as acceptance of this assignment. A copy of this authorization shall be considered as effective and valid as the original.

____________________________________________________________  ______________________
Signature of client/parent                                          Date
(If other than policy holder)