LOGICAL
BEHAVIORAL HEALTH

# PSYCHOLOGICAL TESTING CONTRACT

Welcome to our group practice. This document contains important information about our professional services and business policies. Please read it carefully and make note of any questions that you might have so that we can discuss them during our session. **Please sign your initials on the line provided following each section, indicating that you have read and agreed to our policies. When you sign this document, it will represent an agreement between you and Logical Behavioral Health ("Provider").**

**PSYCHOLOGICAL TESTING SERVICES:** The nature and purpose of a psychological assessment depends on your referring concerns. Such concerns may include identifying learning disabilities, diagnosis clarification, strengths and interests, personality functioning, career fit, fitness for duty, evaluation for medical procedures (such as bariatric surgery), clinical progress assessment, and treatment recommendations. The goal of neuropsychological assessment is to determine the state of attention, memory, language, problem solving, or other cognitive functions, and/or any changes in these domains over time. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where you will be asked questions about your background and current medical symptoms we may use different techniques, such as self-report measures (questionnaires) and standardized performance-based tests. For some individuals, the foreseeable risks, discomforts, and benefits of a psychological assessment may include, but are not limited to: temporary fatigue, frustration, and anxious feelings. Benefits may include, but are not limited to: accurate designation of strengths, impairments, diagnoses, and applicable recommendations revealed through testing.

_____ (please initial)

**APPOINTMENTS AND CANCELLATIONS:** You and the provider will schedule the appropriate units of time (1 unit = 1 hour) required for the completion of testing services for that day. It is not uncommon to break up a battery of tests over several days to reduce testing fatigue. The scheduling of an appointment involves the reservation of time set specifically for you and the Provider. In the event that you need to cancel an appointment, **please inform the Provider of your cancellation by 12:00PM PST one business day in advance**. Please be advised that insurance companies usually do not cover missed or cancelled appointments. Therefore, you are responsible for the **full session fee** for all missed and canceled appointments noncompliant with the cancellation policies. Illness is not an exception unless accompanied by medical documentation.

_____ (please initial)

**PROFESSIONAL FEES**: The professional fee per unit of testing is $225. Depending on the nature and reason for the referral, assessments may take several hours or more of face-to-face testing and several additional hours for scoring, interpretation, and report preparation. Any addition of tests or referral concerns may require additional hours. A sliding scale fee may be applicable for individuals who qualify. If a sliding scale fee is used, any administration fees for computerized scoring or report generation will be considered "pass through" fees that you will be responsible for. If you invalidate a test, you will be responsible for the costs associated with re-administering the test. In addition to testing services, the Provider will charge this amount pro rata for other professional services, including but not limited to, telephone conversations lasting longer than 10 minutes, report writing, attendance at meeting with other professionals you have authorized, preparation of records/treatment summaries, and time spent performing other services requested. Please be advised that the Provider has 15 days to provide letters and treatment summaries, and 30 days to provide treatment records from the time of request. If you become involved in legal proceedings that require the Provider's participation, you will be expected to pay the professional rate even if the Provider is called to testify by another party.

_____ (please initial)

**BILLING AND PAYMENTS:** You will be expected to pay at the beginning of each appointment (via cash, check, or card), whether you are utilizing private pay or health insurance benefits. Health insurance companies will often cover a portion of the cost of psychological/psychoeducational testing. If you are planning on utilizing your health insurance benefits, please be advised that you may be expected to pay the contracted amount upfront, depending on your plan, deductible, and whether or not the Provider is in-network. On occasion, mental health insurance rates (i.e. contracted rates, co-payments/co-insurance rates, deductibles) may change during the course of treatment. Please be advised that should your rates change, you will be expected to pay the difference for these services.

Payment schedules for other professional services will be agreed to when they are requested.

You are responsible for ensuring that your account balance is paid in full. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the Provider will have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, such costs will be included in the claim. In most collections situations, the only information released is information regarding a patient's treatment, his/her contact information, the nature of services provided, and the amount due.

_____ (please initial)

**STRUCTURE OF SERVICES:** Psychological testing services are comprehensive and include multiple components beyond face-to-face administration. These services may include, but are not limited to: clinical interview, test administration, administration of rating scales

and inventories (including self-report and/or informant-report measures), scoring, interpretation of results, record review, collateral contacts (when applicable), and preparation of a written report.

In addition to in-person or direct testing sessions, professional time spent scoring, integrating data, and preparing the written report is considered a standard and necessary part of the evaluation and is billed accordingly.

For billing and documentation purposes, services may be recorded across multiple dates of service. This commonly includes separate entries for (1) administration of inventories or rating scales and (2) professional time devoted to scoring, interpretation, and report writing. As a result, you may see additional dates of service corresponding to these components, even if you are not physically present for those activities.

The number and distribution of service dates may vary depending on the scope and complexity of the evaluation; however, most evaluations include multiple service entries reflecting both direct and indirect professional work.

_____ (please initial)

**INSURANCE BENEFITS:** It is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it is your responsibility to determine whether or not you have coverage, what kind of coverage you have prior to each appointment, and whether or not a prior authorization is required. Please be advised that you will be responsible for any and all claims denied or unpaid by insurance. If you have questions about the coverage, call your health plan administrator. In order for you to receive your insurance benefits, you will be required to authorize the Provider to provide a mental health diagnosis and dates of service. The Provider may have to provide additional clinical information such as treatment plans, summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company records and the Provider will have no control over what they do with it once it is in their possession. It is important to remember that you always have the right to pay for services via private pay to avoid the problems described above.

_____ (please initial)

**CONTACTING ME:** The Provider may not be immediately available by telephone. In the event the Provider is unavailable, you may leave a confidential voice message. The Provider will make every effort to return your call within one business day, with the exception of weekends and holidays. Email and text are not secure ways of communicating personal and confidential information.

If an emergency situation arises, you may call and leave a message stating the nature of the emergency and a telephone number at which you can be reached. The Provider will make every effort to return your call immediately. You may also dial 911 for immediate assistance or dial 988, which is the National Suicide Prevention Lifeline. If the Provider will be unavailable for an extended period of time, a qualified professional will be available for you to contact during his or her absence.

_____ (please initial)

**PROFESSIONAL RECORDS:** The laws and standards of our profession require that the Provider keep treatment records. You are entitled to receive a copy or summary of your records. These professional records can be misinterpreted by untrained readers. Therefore, if you wish to view your records, it is recommended that you review them in the Provider's presence so that you can discuss the contents.

_____ (please initial)

**MINORS:** If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request a verbal agreement from parents that they agree to give up access to your records. If they agree, the Provider will provide them only with general information about your work together, unless there is a risk that you will be seriously harmed, seriously harm yourself, or someone else. In this case, the provider will notify them of the concern. The Provider will also provide them with a summary of your treatment when it is complete. Before giving them any information, the Provider will discuss the matter with you, if possible, and do their best to handle any objections you may have with what the Provider is prepared to discuss.

_____ (please initial)

**CONFIDENTIALITY:** In general, the privacy of all communications between a patient and a psychologist, including that of minors, is protected by law. Therefore, the Provider is not at liberty to release information to another professional or interested party without written permission except where disclosure is permitted or required by law. There are some situations in which the Provider is legally obligated to take action to protect others from harm, even if he or she has to reveal some information about a patient's treatment. Disclosure may be required in the following circumstances:

(1) When there is a reasonable suspicion of child abuse, elder abuse, or abuse of a dependent adult (i.e., an adult who relies on the care of others). In this case, the Provider is required by law to file a report with the appropriate state agency.
(2) If the Provider believes that a patient is threatening serious bodily harm to another, he or she is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
(3) If the patient threatens serious bodily harm to himself/herself, the Provider may be obligated to seek hospitalization for him/her or to contact a family member or others who can help provide protection.
(4) When disclosure is required pursuant to a legal proceeding (i.e., court order).
(5) In the event that the services occurred in our practice. If a similar situation occurs, the Provider will make every effort to fully discuss it with you before taking any action.

The Provider may occasionally find it helpful to consult other professionals about a case. During a consultation, neither your name nor identifying information about you will be revealed. The consultant also is legally bound to keep the information confidential.

_____ (please initial)

**TERMINATION:** The Provider reserves the right to terminate testing services at his or her discretion due to nonpayment, noncompliance, conflicts of interest, lack of participation, hostility or threatening behaviors, or if your needs are outside the scope of the provider's competence or practice. You also have the right to terminate testing services at any time. Unless special arrangements have been made, a duration of 30 days or longer with no clinical activity is subject to termination of services and having your chart closed.

_____ (please initial)

## CONSENT FOR TREATMENT

I, _____, authorize and request that _____, provide psychological assessments, examinations, and/or diagnostic procedures which are advisable during the course of my care as a patient. The frequency and type of assessment services provided will be established by the provider and based on best practices.

I understand that there is no expectation of any type of outcome or finding from psychological assessment services.

I understand that the best outcome is likely to occur with prompt and active participation and engagement in testing services, including (but not limited to) consistent attendance, best effort, and timely completion and return of inventories.

I understand that the findings and diagnostic impressions based on the results of testing services may be difficult and uncomfortable, but that it is part of the assessment process.

I understand that there is a possibility that the findings and diagnostic impressions from psychological assessment services may not match my expectations and I hold the Provider harmless from the results of any assessment.

As part of this evaluation, the Provider will design and administer a personalized battery of psychological tests and assessment procedures. The specific measures selected are determined based on the Provider's professional judgment as a licensed psychologist, taking into account the referral question, clinical presentation, relevant history, and evolving findings during the evaluation process.

Test selection is guided by established professional standards, current best practices in psychological assessment, and considerations of medical necessity. The exact instruments used may vary and may be adjusted during the course of the evaluation to ensure a comprehensive and clinically appropriate assessment.

By consenting to this evaluation, I am consenting to the Provider's selection and administration of assessment instruments and procedures as clinically indicated. I understand that not all tests can be specified in advance and that the evaluation process may involve modifications based on ongoing clinical judgment.

I retain the right to ask questions about the evaluation process and to decline participation in any specific procedure; however, doing so may limit the scope, validity, or completeness of the evaluation and any resulting conclusions.

I understand that my participation in psychological testing is completely voluntary and that I may terminate testing services at any time.

I have received a copy of the *Psychological Testing Contract*. I understand that the purpose of these guidelines is to clarify the nature of our professional relationship.

My signature indicates that I have read and fully understand the information in the *Psychological Testing Contract* and I agree to abide by its terms during our professional relationship.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian/Financial Guarantor's Signature Date

_____ _____

Psychologist's Signature Date