PRINCETON Neuropsychology at RSM | Sports Concussion Center of New Jersey

8/2023

Welcome to Princeton Neuropsychology at RSM and Sports Concussion Center of New Jersey

We look forward to meeting you at your first appointment. In preparation, please PRINT, SIGN, and RETURN either a scanned copy or a photo of the following forms, along with a photo ID (and insurance card if applicable), at least 48 hours before your appointment.

*Please Note: We **cannot** accept printed/typed signatures.*

If you have any questions about how to best complete these forms, please do not hesitate to contact us by phone or e-mail: 609-895-1070 / Manager@princetonneuropsychology.com

Sincerely,

Princeton Neuropsychology at RSM and SCCNJ

manager@PrincetonNeuropsychology.com
609-895-1070 609-896-2030
100 Canal Pointe Blvd, Suite 210
Princeton, NJ 08540

Rosemarie Scolaro Moser, PhD, ABN, ABPP-RP
Director
NJ Psychology License #SI 02148
PA Psychology License #PS 004532L
APIT #3394

PRINCETON Neuropsychology at RSM | Sports Concussion Center of New Jersey

8/2023

Independent Psychological/Neuropsychological Evaluation/Examination
Informed Consent Contract

This Independent Evaluation/Examination is being conducted at the request of

_____ and is therefore somewhat different than other psychological/neuropsychological services. It is important for you to understand how an independent evaluation/examination differs from more traditional psychological/neuropsychological services.

While the result of this examination may or may not be helpful to you personally (or in the case of a minor, the minor you represent), the goal of this evaluation is to provide information about how the person is functioning psychologically or neuropsychologically to the entity or agency requesting the evaluation. This entity may be an employer, a school, an attorney, an advocate, a third-party payor, yourself, or other organization/agent that is requesting the independent opinion.

In most cases, the evaluation is intended to determine the need for services or treatment, determine the type of treatment or services, and/or review the appropriateness of the services or treatment already provided so that the entity will determine whether, or to what extent, those services will be administered, offered, covered, or paid for by the entity or third party. In some cases, the evaluation is intended to render an opinion regarding a person's past or present mental status, behavior, or fitness to engage in certain activities or occupations.

There are exceptions to the confidentiality or privacy of this examination. Some exceptions might include a determination on our part that the person being evaluated is dangerous to another person or to himself/herself, or if the person being evaluated reveals information that a child has been abused. We would also have to release this information if a court orders us to do so. There may be other examples where the law requires us to release the information obtained during the evaluation. We will discuss these situations on a case-by-case basis if they apply.

The entity that has requested this evaluation is our client and has authority over the results, including whether and to whom any information will be released. In addition, because the evaluation was requested for the purposes of an independent opinion and is not for the purpose of treatment or services at our Center, the confidentiality may have fewer legal protections.

Participation in this evaluation is voluntary. We will not conduct the evaluation without your signature on this document. You also have the right to stop the evaluation at any time. There may be legal or insurance payment consequences if you stop the evaluation. In addition, if appointments are not kept or are cancelled within 24 hours of the appointment time, the entity requesting the evaluation will incur charges for the unused time that has been set aside for the evaluation.

The evaluation itself usually consists of two parts: an oral interview and psychological/neuropsychological testing. In addition, it may be necessary for us to review other related material such as court records, depositions, transcripts, medical records, etc.

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If, at any time, you have a question about any aspect of the evaluation or these procedures, please feel free to ask us. In addition, if at any time you need a break from the evaluation, please let us know and we will stop. Also, please understand that this evaluation is: 1) for an expert independent opinion only; 2) does not imply a treating relationship; and 3) the person being evaluated is not a patient of the Center or of its doctors/staff.

I have read and agreed to the above:

Signature of person being evaluated if at Least 18 years old, or of Legal Representative/Parent/Guardian

Print Name

Signature of Minor if 13 years old or older

Print Name

Date

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CONFIDENTIAL

INTAKE INFORMATION

(Please Complete All Applicable Sections)

Name_____ Birthdate _____Today's Date_____

Gender: _____ Age _____ Social Security # (last 4): _____

Home Address _____ City/State/Zip_____

Preferred Phone _____Alternate Phone _____

Preferred Email_____ Race/Ethnicity_____

Employer & Occupation-**OR**-School _____

Highest/Current Grade in School _____Place of Birth _____ Religion, if applicable _____

Circle One: Single / Married / Separated / Divorced / Widowed

For ADULTS: Spouse's Name, Age & Occupation_____

Children's Names & Ages_____

For CHILDREN: Parents' Names & Occupations _____

Sisters'/Brothers' Names & Ages _____

Emergency Contact Name & Phone _____

Name of Primary Care Physician, Pediatrician, or Psychiatrist_____

How did you hear about this service? Who referred you? _____

Describe below the difficulties or symptoms for which you are seeking assistance.

Please list any significant past or present medical or health related conditions, treatments, injuries or surgeries. Are you now receiving treatment for any of these conditions?

Please note if you have ever sustained a head injury, concussion, or been in a work-related, sport-related, or motor vehicle accident. Please describe and list dates.

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Have you ever been hospitalized for a medical, substance/alcohol abuse, or psychiatric problem? If yes, where and when?

Are you now receiving, or have you ever in the past received, any type of mental health or psychiatric treatment or personal or career counseling? If yes, please list diagnoses, dates, type of treatment.

Have you ever been diagnosed with a learning or attention or memory disorder? If yes, please explain.

Has anyone in your family ever received psychological/psychiatric assistance or been diagnosed with a learning or attention or memory disorder? If yes, please describe.

Please list name and dosage of any medications you are taking: Do you use other non-prescription drugs or substances? If yes, please describe.

Do you drink alcohol? If yes, how many drinks per week? Please describe.

Do you smoke cigarettes? If yes, how many cigarettes per day?

Do you smoke a pipe/cigars?

Do you vape?

Do you chew tobacco?

Do you use cannabis?

Are you [or for children- is/are your parent(s)] a present or past military member? Yes__ No__

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

As part of your evaluation/testing/treatment, we may engage in video-conferencing or other electronic communication. Please be aware of and agree to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are still responsible for full payment.
- As your psychologist, we may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.
- We use a secure, HIPAA compliant video platform for conferencing and strive to safeguard your privacy. However, if needed, we may communicate with you via email, FaceTime, Skype, Zoom, Google docs, telephone, or other modes, all of which may not be fully secure, private, or HIPAA Compliant.

Person's Name: _____ Date_____

Signature of Person if 13 yrs or older _____

***If Person is under 18 years of age**:*

Parent/Guardian Name _____

*Parent/Guardian Signature*_____

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Telehealth Call and Emergency Contact Form

Please complete all information

Date of Completion of Form: _____

Name: _____

Preferred Phone: _____

Address: _____

Preferred email address: _____

Place of Treatment: _____

Emergency Contact Person and Phone: _____

Local Emergency Services: _____

Please initial here that patient promises that they will not record the session and that the session will be private and secure, unless the patient indicates that there is someone else in the room and that the other person will be made visible to the treating doctor/staff. Yes____

Name: _____ Date_____

Signature of Person if 13 yrs or older _____

If Person is under 18 years of age:
Parent/Guardian Name _____

Parent/Guardian Signature_____

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HIPAA: Notice of Privacy Practices

8/2023

Notice of Doctor's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. **YOU WILL BE ASKED TO ACKNOWLEDGE THAT YOU HAVE RECEIVED OUR NOTICE OF PRIVACY.**

Uses and Disclosures for Treatment, Payment, and Health Care Operations
We (heretofore Princeton Neuropsychology at RSM/SCCNJ and their staff) 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:

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

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 doctor.

Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

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 practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of practice group such as releasing, transferring, or providing access to information about you to other parties.

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 will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation 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.

- We will also obtain an authorization from you before using or disclosing: PHI in a way that is not described in this Notice. Psychotherapy notes · PHI for marketing purposes · PHI in a way that is considered a sale of PHI.

You may revoke all such authorizations (of PHI or psychotherapy 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) 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.

Uses and Disclosures with Neither Consent nor Authorization
We may use or disclose PHI without your consent or authorization in the following circumstances:

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- Child Abuse: If we have reasonable cause to believe that a child has been subject to abuse, we must report this immediately to the New Jersey Division of Youth and Family Services.
- Adult and Domestic Abuse: If we reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, we may report the information to the county adult protective services provider.
- Health Oversight: If the New Jersey State Board of Psychological Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We must inform you in advance if this is the case.
- Serious Threat to Health or Safety: If you communicate to us a threat of imminent serious physical violence against a readily identifiable victim or yourself or to the public and we believe you intend to carry out that threat, we must take steps to warn and protect. We also must take such steps if we believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps we take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents
  if the intended victim is under 18, and warning your parents if you are under 18.
- Worker's Compensation: If you file a worker's compensation claim, we may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Person's Rights and Doctor's/Staff Duties

Person'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. We may choose to provide you with a summary of your record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial 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. On 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). On 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.

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Notice of Doctor's Policies and Practices to Protect the Privacy of Your Health Information

- Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.
- Right to Opt out of Fundraising Communications. You have a right to decide that you would not like to be included in fundraising communications that I may send out.

Psychologists' 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 post such a notice in our offices and give you a copy at your next appointment.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Dr. Rosemarie Scolaro Moser, Director, 609-896-1070 and/or the NJ State Board of Psychological Examiners in Newark, NJ, as posted in our office.

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.

Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on April 14, 2003 & September 23, 2013.
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. We will provide you with a revised notice by posting in our office and giving you a copy at your next appointment.

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Acknowledgement of HIPAA Rights

By your signature below, you indicate that you have received and/or read a copy of the "*Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.*"

The notice is available on websites: www.sccnj.com and www.rsmpsychology.com as well as in the offices of Princeton Neuropsychology at RSM and SCCNJ.

_____ _____

Signature of Person (13 years or older) Today's Date

_____ _____

Print Person's Name Birthdate

_____

Signature of Parent/Guardian if person is under 18 years

_____

Signature of other Parent/Guardian if required

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CONSENT FOR DISCLOSURE OF PATIENT RECORDS OR COMMUNICATION

(Only complete this form if you would like us to share your information with another person, another doctor, or your insurance company)

I hereby authorize **Princeton Neuropsychology at RSM/SCCNJ** to disclose information and/or receive information to the extent or nature indicated to/from Recipient Name/Address/Contact Info: _____ _____ for the purpose of **case consultation, record release, and/or billing**. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose and may include the following items (unless crossed out by me):

Drug and/or alcohol abuse information
Information regarding Immunodeficiency virus (HIV) including laboratory test results
Diagnosis of AIDS or ARC, if applicable
History and physical examinations
Psychological & neuropsychological test results
Raw data from psychological and neuropsychological tests
Clinical notes, including correspondence and billing/insurance information
Psychological and neuropsychological reports
Other: _____

Regarding: **(Name)**_____ whose date of birth is _____ and whose social security number is _____.

I understand that in New Jersey the communications between patients and psychologists are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately and will expire after 365 days from the date of signature. However, I also understand that I may revoke my consent before 365 days elapses by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connection with the aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan that is not ERISA exempt cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is released, there is potential for that information to be redisclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original. I hereby release Princeton Neuropsychology at RSM/SCCNJ and its employees, personnel, officers, directors, and professional health care providers from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Signature (13 years or older):_____

Parent/Legal Guardian Signature (if Person is under 18 years of age):_____

Other Parent/Legal Guardian Signature, *if required*:_____

Today's Date_____

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