Wasatch Pediatric Neuropsychology, Inc.
Julien Smith, Ph.D.
Pediatric Neuropsychologist
231 East 400 South, Suite 335
Salt Lake City, UT 84111
Phone (801) 363-1189
Fax (801) 363-1196

Consent for Care

This document provides information about clinical services that we provide and represents an agreement of consent for care. Attached to this document is a notice that explains information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of personal health information (PHI) for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of your first session.

Your signature on this consent form represents an agreement for care. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or, if you have not satisfied any financial obligations you have incurred.

You have a right to refuse treatment at any point during our work together. It is your responsibility to choose the provider and type of treatment that best suits your needs. You have the right to ask questions concerning the findings of an evaluation, and the right to raise questions about our therapeutic approaches and the progress that is being made at any time. If you feel that progress is not being made, please bring it to our attention quickly. We will make every effort to respond to your concerns. We are always happy to facilitate a referral to other resources if you wish.

Consent and Confidentiality For Minors
As psychologists, we must treat the legal guardian(s) of the child as the patient with respect to protected health information relevant to that representation (letting the guardian exercise the privacy rights that a patient would normally exercise, e.g., receiving notice, consenting to disclosure, having access to their records and the right to amend).

Divorced or Separated Parents

When parents are separated or divorced, it is preferable for both parents to consent to evaluation or treatment for their child and to agree regarding payment for these services. Unless there is legal documentation to the contrary, either parent may request access to the child's information. Please note that we do not perform custody evaluations and therefore do not make custody or visitation recommendations.

Consent and Confidentiality with School/Agency Involvement
There are times when we provide service to an individual that is funded through a school district or outside agency. In this case, the agency and the parents/legal guardians are required to provide consent to care. In addition, it needs to be understood that there is an open exchange of information between the parents/legal guardians, agency, and Children's Neurodevelopmental Services, such that any information given to us by the agency can be shared with the parents/legal guardians and any information provided to us by the parents/legal guardians can be shared with the agency.

Contacting Us
We are often not immediately available by telephone. Therefore, we cannot provide consistent crisis care. If you think that you may need this level of support, please let know so that we can determine whether we are appropriate providers of if we need to develop a crisis plan for you. Leaving a message on our voicemail is usually the only way to reach us. We will make every effort to return your call on the days that we are scheduled to work. We will keep you informed of our work schedules. If either of us unavailable for an extended length of time we will provide you with the name of a colleague to contact, if necessary. If you are difficult to reach, please inform us of some times when you will be available. If you are in crisis, you should call 911, or go to the nearest Emergency Room and ask for the psychologist or psychiatrist on call, or call the University Neuropsychiatric Institute (UNI) crisis line at (801) 583-2500.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I have read and understand the above policies and have had the opportunity to ask questions. I give permission for evaluation and treatment for my child, and state that we are/I am the parent or legal guardian for this individual.

_____
Patient's name:

_____ _____/_____
Date Signature of Responsible Party/Relationship to Patient

_____
WPN Staff