SUMMIT PSYCHOLOGICAL SERVICES

1350 Old Freeport Road, Suite 1A
Pittsburgh PA 15238
Phone: 412-406-7734 Fax: 412-406-7742

300 Northpoint Circle, Suite 105
Seven Fields, PA 16046
Phone: 724-591-8980 Fax: 724-591-8972

Receipt of Notice of Office Policies, Financial Policies, Patient Information Guide, and Notice of Privacy Practices (HIPAA)

Patient Name: ________________________________ D.O.B.:__________________

Please place a check mark beside each item to indicate that you have reviewed and received a copy of the following (seen on the listed pages of the New Patient Information Packet):

— Office Policies (pg 2)

— Financial Policies (pg 4)

— Outpatient Treatment and Patient Information Guide (pg 6)

— Notice of Privacy Practices (HIPAA) (pg 11)

My signature denotes that I have received the above information and reviewed it to my satisfaction.

_______________________________________ ___________________________

Patient (14 years and older) - or - Parent/ Legal Guardian Date

_______________________________________ ___________________________

Provider Representative Date

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Informed Consent

(Mandatory Signature)

Patient Name: ________________________________ D.O.B.:__________________

I, ______________________________, or my child __________________________ , have/has voluntarily participated in an evaluation at Summit Psychological Services Outpatient Treatment. I understand that the diagnosis and the extent of any specific problems will be adequately explained to me. Also, I understand I will be informed of the risks and benefits of any proposed treatment, the risks and benefits of alternative treatments, and the likely effect of no treatment.

I understand the following statements:

- Effective January 1st, 2015 Pennsylvania enforced a new law regarding the mandatory reporting of child abuse. This has resulted in some important updates to the limits of confidentiality. All providers at Summit Psychological Services may be required by Pennsylvania Law (Act 31, 2014) to report if they have any reason to suspect, based on their professional judgment, that a child is being or has been abused. They are required to report any suspicion to the authority or government agency vested to conduct child abuse investigations. They are mandated to report suspected child abuse if anyone aged 14 or older tells them that he or she committed child abuse, even if the victim is no longer in danger. They are also mandated to report suspected child abuse if anyone tells them that he or she knows of any child who is being abused.
- I will refrain from any action or omission designed to deceive or manipulate any healthcare professional into prescribing medications or providing duplicate services.
- My financial obligations about the recommended treatment have been fully explained to me.

I have read the above information and understand what treatment services will be provided and I voluntarily consent to receive the recommended treatment.

_____________________________________ ___________________________

Patient (14 years and older) - or - Parent/ Legal Guardian Date

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Consent for Psychological Treatment and Release of Information to Insuring Party

(Mandatory Signature)

Patient Name: ______________________________ D.O.B.: ________________

By signing this form, I hereby voluntarily consent to treatment through Summit Psychological Services, and further authorize said organization, as holder of medical or other information about me, to release information as needed to the insurance carrier(s) responsible for payment of services rendered. The information that I hereby authorize for release with this form is limited to the information that is necessary for the processing of the claim by the insurance carrier(s) for payment for professional services being provided by Summit Psychological Services.

I hereby acknowledge and authorize that a copy of this consent for treatment and release of information will serve as an original for all purposes stated in this document.

I hereby request and authorize the payment and assignment of benefits for treatment provided by and through Summit Psychological Services, to the same, *regulations pertaining to the assignment of medical benefits notwithstanding*.

____ ______________________________

Patient (14 years and older) - or - Parent/ Legal Guardian Date

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E-Mail Consent Form

(Optional)

Patient Name: ___________________________________ D.O.B.:____________________

Patient E-mail Address: ____

1. RISK OF USING E-MAIL

Summit Psychological Services offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has several risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an e-mail.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Summit Psychological Services Providers will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Providers cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical records, such as staff and billing personnel, will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
d. If the patient's e-mail requires or invites a response from the Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, developmental disability, or substance abuse.
f. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform Provider of changes in his/her e-mail address.
c. Put the patient's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to Provider.
f. Inform Provider that the patient received an e-mail from Provider.
g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to Provider.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

____ ____________________________

Patient/Parent or Legal Guardian Signature Date

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Authorization to Disclose Information to Primary Care Physician

(Mandatory Signature)

Patient Name: ________________________________ D.O.B.:___________________

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, ___________________________, hereby authorize Summit Psychological Services
(Please print patient's name)

Please check one:

_____ **To exchange any applicable information with my Primary Care Physician**

_____ **Not to release information to my Primary Care Physician**

____ ____________________________

Patient (14 years and older) - or - Parent/ Legal Guardian Date

Primary Care Physician's Name, Address & Phone:

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Note to Behavioral Health Care Provider:
Please maintain original copy in patient's file