Austin Psychological & Testing Center
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New Patient Practice Policies Checklist

Please read the following items carefully and initial next to each item indicating that you have read and fully understand it. Please ask the office staff if you have any questions.

_____ I understand that it is my responsibility to maintain knowledge of my appointment dates and times. If I receive a reminder phone call the day before my appointment, it is offered as a courtesy and is not guaranteed.

_____ If the patient is a minor, I understand it is my responsibility to provide documentation (ex: court documentation) if I am not a custodial parent or if there are issues regarding custody of the child and the ability to provide consent to treatment.

_____ If the patient is a minor, I understand that if the minor's parents are divorced or separated, APTC needs both parents' consent and involvement in the testing process.

_____ I understand that it is my responsibility to return all paperwork regarding my testing in a timely manner.

_____ I understand that patient records or medical history will not be discussed over the phone.

_____ I understand that no records will be released to outside parties without a signed authorization for release.

_____ I understand that it is my responsibility to turn in all new patient paperwork prior to my initial consultation appointment and if I am having trouble doing so I need to alert office staff immediately.

_____ I understand that it is my responsibility to turn in all questionnaires prior to my testing appointment and if for any reason should I not do so, my evaluation will be completed as is, without the forms after 30 days.

_____ I consent to receiving text messages as appointment reminders.

Confidentiality

_____ I understand that APTC clinicians are required to notify appropriate authorities if abuse of a child, elderly, and/or disabled individual is disclosed.

_____ I understand that APTC clinicians are required to notify appropriate authorities if the client is deemed in immediate danger of harming self or others.

_____ I understand that, in the event that records are subpoenaed, there is the possibility that psychological evaluation results may be released to the court.

_____ I understand that APTC does **NOT** conduct psychological evaluations for court-related purposes. If this evaluation is needed for court purposes, APTC is happy to provide referrals to professionals who conduct forensic-related evaluations.

_____ I understand that recommendations for further treatment made by APTC are provided as a courtesy. This does **NOT** guarantee that third parties (for example, physicians, schools, etc.) will incorporate the recommendations made. That is, final decisions for future treatment/accommodations are ultimately decided by that third party (e.g. physician, school, etc.).

- _____ If recommendations are made regarding accommodations in a person's place of employment, I understand that these recommendations are provided <u>as a courtesy only</u>, and final decisions for work accommodations are ultimately decided by the place of employment.

- _____ If recommendations are made regarding academic accommodations, I understand that these recommendations are provided <u>as a courtesy only</u>, and final decisions for academic accommodations are ultimately decided by the academic institution.

Limitations

In psychological assessment, insurance companies will only cover what they deem is medically necessary for diagnosis and do not cover evaluations for legal, occupational, or academic purposes. As such, the recommendations made by APTC clinicians are provided as a courtesy only, and any decisions for possible accommodations and further treatment planning is ultimately decided by third parties, such as academic institutions, places of employment, physicians, etc.

**Excerpt from Tufts Health Plan:

"Psychological testing and assessments are not covered under the following circumstances:

- The testing is being conducted primarily for educational (including learning disabilities), vocational or legal purposes."

_____ I have read and agree to the HIPAA Patient Privacy Agreement.

Date: _____

Printed name of person completing this document: _____

Name of Patient _____Relationship to the patient: _____