Gifted Testing Welcome Pack

Welcome and thanks for landing here with me! I am looking forward to meeting your child and providing the gifted testing results.

Here is what you need to know:

- Make sure your child has a good night's rest
- Good breakfast
- Is not sick
- Brings any corrective reading glasses

What you can expect:

- The test is approximately 1 ½ hrs.
- Detailed results within 1 week
- 2 copies (digital and paper)

Please advise if you will be canceling the appointment at least 24 hours before the start time. If not a $50 charge will be deducted from your card. If you are running late you have a 15-minute forgiveness window, please text or call.

GIFTED TESTING INTAKE FORM

Date:_____ Client Name:_____

DOB: _____ Age:: _____

Legal Guardian: _____ Relationship:_____

Phone:_____

Emergency Contact:_____ Relationship:_____

Phone:_____ Address:_____

EDUCATIONAL HISTORY

Current School Name:_____ Grade _____:

- Public / Private/ Charter _____
- Phone number:_____

SOCIAL HISTORY

Does your child participate in any special interests, hobbies, sports? How does your child relate to other children? _____

LANGUAGE DEVELOPMENT

How many languages does your child speak? If more than English, which? What language is spoken at home? _____

What is your child's dominant language?_____

If your child was not born in the United States, what is the level of English proficiency? Did or does your child attend ESOL or ELL classes at school? _____

Does your child qualify for free/reduced lunch at school? _____

Consent to Treatment and Use of Protected Health Information
(for treatment, payment, and healthcare operations)

Client's Name: _____

I, the undersigned client and/or guardian, consent and authorize Dr. Eva Benmeleh (Dr. Eva Therapy) to administer treatment to the client. Treatment includes gifted cognitive testing. I understand that Dr. Eva Benmeleh originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I consent to the use and disclosure of protected health information about the client for treatment, payment, and healthcare operations. This means that information about client's health will be used by Dr. Eva Benmeleh or disclosed to other people or organizations whenever needed to:

- Provide treatment to client or arrange for treatment by another health care provider
- Arrange for payment for services to client
- Enable other healthcare organizations that provide treatment to client or pay for services to review the quality and appropriateness of care received, conduct other healthcare operations

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to Dr. Eva Benmeleh for services rendered. I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary.

The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I fully understand and accept the terms of this Consent and acknowledge the receipt of the Notice of Privacy Policies detailing how my information can be used and disclosed under Federal and State law. I understand the contents of the Notice. I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information. I understand that there is no time limit on this consent. I understand that I may revoke this consent at any time.

I am the client/ guardian of the client who is the subject of the health records that will be used or disclosed.

I consent to treatment and agree to the use and disclosure of my health information as described in this consent.

_____

Signature of Client (Guardian) Print Name Date

Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have acted in reliance on it.

LIMITS ON CONFIDENTIALITY The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary.

Reasons I may have to release your information without authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient to defend myself.
- I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

ClientRightsandTherapistDuties
Use and Disclosure of Protected Health Information:

- For Treatment: If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. An authorization is required for most uses and disclosures of psychotherapy notes.
- For Payment: I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- For Operations: I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Client's Rights:

- Right to Treatment: You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- Right to Confidentiality: You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am 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.

- Right to Choose – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Please request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- Right to Amend – If you believe the information in your records is incorrect and/or missing important information, you can ask me to make certain changes, also known as amending, to your health information. You must make this request in writing. You must tell me the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- Right to a Copy of This Notice – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details.
- Right to Choose Someone to Act for You – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- Right to Release Information with Written Consent – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss the effects of releasing the information in question to that person or agency.
- Right to Terminate – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice.
- Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgment that you have received the HIPAA notice form.

_____

Client Signature Print Name Date

_____

Eva Benmeleh, PhD Licensed Clinical Psychologist #8656 Date