Dr. Laila Spina
CLINICAL PSYCHOLOGY & NEUROPSYCHOLOGY

Pacific Neuropsychology Services, LLC
P.O. Box 3805
Honolulu, HI 96812
Phone: 808-599-7676
Fax: 808-599-7900

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be Used, Disclosed and Safeguarded, and how you can get access to this information. Please review it carefully.

I. My Responsibility:

Protected health information (PHI) is any information regarding your health care that can identify you as the recipient of the health care services. I respect the privacy of this information and will maintain its confidentiality in a responsible and professional manner

The law requires me to provide you with this notice and abide by its terms. It maybe necessary to change the terms of this notice in the future. If this Notice is revised, the amended terms shall apply to all the health information that I maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, my legal duties or other privacy practices described in the Notice, I will provide copies to my patients and others.

Effective Date of this Notice: June 20, 2006.

II. Uses and Disclosures of Your Protected Health Information

I will not use or disclose your protected health information without your specific written authorization unless allowed or required by law to do so. Any specific written authorization may be revoked, at any time, in writing, except to the extent I have taken action in reliance on that written authorization before you have revoked it. Under federal law, I am permitted to use and disclose personal health information without authorization for your treatment, for payment and for health care operations. I may also use and disclose your personal information without authorization for the following purposes as required or permitted by law. If feasible, I will inform you promptly that I have made such a disclosure.

- To state or federal agency to report suspected abuse, neglect or domestic violence. If such a report is optional, I will use my professional judgment in deciding whether or not to make such a report.
- In the course of a judicial or administrative proceeding, in accordance with my legal obligations.
- To a law enforcement official for certain law enforcement to locate someone such as a material witness or make a report concerning suspected criminal conduct.
- To public safety authorities consistent with my legal and ethical obligations based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.

- To family members, close personal friends, your personal representative or other person responsible for your care to the extent necessary to help with your health care or with payment for your health care when you are unable to provide authorization due to, for example, being incapacitated or some other emergency circumstance. Any such disclosure will be limited to information directly related to the person's involvement in your care and may include notification of your location, general condition, or death. I will use my professional judgment to determine what is in your best interest. I will also use professional judgment to make decisions in your best interest about allowing someone to pick up medicine or medical information for you.

- For certain specialized government functions, as authorized by law. Such as military authorities; determination of veterans benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety and security of correctional institutions.
- To health oversight agencies authorized by law to facilitate auditing, inspection, or investigation related to my provision of health care, or to the health care system.

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- To business associates who are performing services on my behalf. For example, I may contract with another psychiatrist to cover in my absence; contract with a company to maintain my computer systems, or to do my typing or billing. Business associates are obligated to safeguard your health information. I will share with my business associates only the minimum amount of health information necessary to assist me.

- To coroners, medical examiners, funeral directors and organ procurement entities to assist in their duties.
- To private and public entities to assist in disaster relief efforts. If you are unavailable because, for example, you are incapacitated, I will use my professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.
- To public health authority, for example, to report disease, injury, or vital events such as death. To the Food and Drug Administration (FDA) in order to report an adverse event or a defect related to a medication.

III. Your Protected Health Information Rights

Under the law, you have certain rights regarding the health information that I collect and maintain about you. In order to exercise any of your rights described, you must submit your request in writing. You have the right to:

- Request that I restrict certain uses and disclosures of your health information; I am not, however, required to agree to a requested restriction

- Request that I communicate with you by alternative means, such as calling only at home, using a cell phone, P.O. Box or work address. I will accommodate reasonable requests for such confidential communications.

- Request to review, or to receive a copy of, the protected health information about you that is maintained in my files, including medical records and billing records but not psychotherapy notes. Requests must be in writing and if I am unable to satisfy your request, I will provide you a written explanation. If you request copies, I will charge you $0.50 for each page, and postage if you want the copies mailed to you.

- Request that I amend the health information about you that is maintained in my files. Your request must explain why you believe my records about you are incorrect, or otherwise require amendment. I may deny your request if I did not create the information you want changed or for certain other reasons. If I deny your request, I will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed and placed in your record.

- Request a list of my disclosures of your health information. This list will not include certain disclosures, such as those made for treatment or payment.

IV. To Request Information or File a Complaint:

If you desire additional information or have any question about this notice, please contact me. If you believe your privacy rights have been violated, you may file a written complaint with me and /or with the Secretary of Health and Human Services (HHS). I cannot, and will not, make you waive your right to file a complaint with HHS as a condition of receiving care from me, or penalize you for filing a complaint with HHS.

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PRIVACY PRACTICES ACKNOWLEGEMENT

Acknowledgment of Receipt of Notice of Uses and Disclosures of Protected Health Information
Authorization for Treatment, Release of Information, Assignment of Benefits and Acknowledgment of Responsibility for Payment for Physician Services

- I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received a copy of the Notice from Pacific Neuropsychology Services.
- I hereby give consent to Pacific Neuropsychology Services to provide whatever treatment is deemed necessary.
- I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these and related services.
- I allow fax transmittal of my medical records, if necessary.
- I request that payment of authorized Medicare and other insurance benefits be made to me or on my behalf to the physician of Pacific Neuropsychology Services for any services furnished me. This assignment will remain in effect until revoked by me in writing.
- I understand that payment of charges (i.e. co-pays, balance after insurance payment received, etc) incurred is due at time of service unless other definite financial arrangements have been made prior to treatment.
- I understand that a late monthly fee of 1.5% or 50 cents minimum will be charged to all accounts past 60 days. I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization. I also acknowledge receipt of Notice of Uses and Disclosures of Protected Health Information.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Informed Consent for Psychotherapy or Psychotherapeutic Consultation

I am a licensed clinical psychologist. State and professional psychologists' standards suggest that you be informed of all possible contingencies that might arise in the course of short-and long-term therapy. Please check to be sure you have read, understood, and discussed all questions with me. An informed consent has the force of contract, so we cannot proceed until we reach an agreement on all items.

What Is Psychotherapy?
Psychotherapy is both a way of understanding human behavior and of helping people with their emotional difficulties and personal problems. Psychotherapy typically starts with an assessment of problematic symptoms and maladaptive behaviors that often intrude into a person's social life, personal relationships, school or work activities, and physical health. Specific psychotherapeutic strategies may be employed to alleviate specific problems causing distress such as depression, anxiety or relationship problems. Self-knowledge is seen as an important key to changing attitudes and behavior. Psychotherapy may involve the development of insight as to how our physical health may be compromised in many ways by emotional and relationship issues. Therapy is designed to help clients of all ages understand how their feelings and thoughts affect the ways they act, react, and relate to others. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client has a unique opportunity to view themselves more accurately, and to make connections between past and current conflicts that illuminate the way one relates to oneself and to others.
Clients are encouraged to talk about thoughts and feelings that arise in therapy, especially feelings toward the therapist. These feelings are important because elements of one's history of important affections and hostilities toward parents and siblings or significant others are often shifted onto the therapist and the process of therapy.

Psychotherapy can be relatively short-term (8-16 weeks) when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date can be set. Psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve painful conflicts, and better integrate all the parts of their personalities.

Note on Cancellations: Due to the long-term nature of my practice, I must hold you responsible for all regularly scheduled consultation sessions whether or not you are able to attend. Should it be necessary for you to cancel an appointment, I request that you give two full working days notice. Repeated missed sessions may result in termination of therapy. Neither you nor I can bill your insurance for missed sessions.

Independent Practice: While I share office space with other mental health professionals, including Gayle Hostetter, Ph.D., and Tracie Umaki, Ph.D., our professional practices are independent. I am not partners with, nor do I have any legal association with any other mental health professional.

Confidentiality: State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. A situation in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of confidential information by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.** We can discuss some foreseeable possibilities together.
6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the therapist from others involved in your treatment.
7. I may at times speak with professional colleagues about our work without asking permission, but your identity will be disguised.
8. Clients under 18 do not have full confidentiality from their parents.
9. It is also important to be aware of other potential limits to confidentiality that include the following:
    a) All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
    b) Cell phones, portable phones, faxes, and e-mails are used on some occasions.
    c) All electronic communication compromises your confidentiality.

Fees: The fee for service covers a 50-60 minute session. Unless other arrangements are made, your insurance will be billed for psychotherapy and you will be responsible for any co-payments and amounts that are not covered by insurance.

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as seeking consultation, refraining from dangerous practices, coming to sessions sober, etc.), or if some problem emerges that is not within the scope of competence of the therapist. Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need of psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may be emotionally painful at times. Patients have the right to refuse or to discontinue services at any time.

Agreement for Psychotherapy Consultation

I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations. I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of her professional association as well as the laws of the state of Hawaii governing the practice of psychotherapy and that she is liable for infractions of those standards.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with my therapist, including appropriate compensation for her time involved in preparing for and doing court work. I understand that my therapist from time to time makes teaching and research contributions using disguised client material. By consenting to treatment I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration.

Arbitration Agreement

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL or

psychological MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT.
Article 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Hawaii law, and not by lawsuit or resort to court process except as Hawaii law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures. This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

Client Signature: _____ Date _____

Therapist Signature _____ Date_____

Legal Parent or Guardian Signature _____ Date _____

Person you give permission to Laila Spina, Psy.D. to communicate with in the event of an emergency such as danger to self, danger to others or severe psychological distress:

Contact Name: _____ Relationship to you: _____

Phone: _____ Address: _____

Second Contact Name: _____ Relationship: _____

Phone: _____ Address: _____

Statement of the Therapist
This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Date_____ and Initials of Therapist _____.

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Electronic Communications and Social Media Policy

This document describes how I conduct myself as a psychologist on the Internet, email, texting, instant messaging, and social networking, and how you can expect me to respond to various electronic interactions that may occur between us. If you have any questions about anything within this document, I encourage you to bring them up at any time. As new technology develops and the Internet changes, I may update this policy.

FRIENDING & FOLLOWING

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.), because these are not private or secure, and I think it can compromise our confidentiality and privacy. It may also blur the boundaries of our professional relationship. Anyone who may view a list of my friends or contacts anywhere online should expect that that they will not find client names on that list.

I do participate in social networking sites as an individual, but this is unrelated to my professional practice. For my professional practice, I maintain a website at drlailaspina.com. I do not follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please mention them in our sessions.

INTERACTING

Please do not use messaging on social networking sites to contact me unless you fully assume the risk that these sites are not secure and I may not read these messages in a timely fashion. Engaging with me in public online could compromise your confidentiality. Potentially, it also may create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you want to contact me between sessions, the best way to do so is by phone. Direct email or text messaging are second best for quick, administrative issues such as changing appointment times. Remember, however that none of these electronic services is truly confidential. I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrators of the Internet service providers. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal medical record.

An individual has the right under federal privacy rules (HIPAA) to request and have a health care provider communicate with him or her by alternative means or at alternative locations, if reasonable. For example, I can accommodate a request to communicate by encrypted text or email, or by phone, if you request it. If you communicate with me using unsecured email or text messaging, for example, I may assume that is acceptable to you. The main thing is that you should be aware of the risks.

BUSINESS REVIEW SITES

You may find my psychology practice on sites such as Yelp, Healthgrades, Angie's List, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers

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and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. Please take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

Thank you for taking the time to read this.

Please feel free to ask questions or raise other concerns.

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PATIENT INFORMATION **DATE:**

First Name: Middle: Last Name:

Address:

City/State/Zip:

DOB: SSN:

Cell Phone: Home Phone: Work Phone:

Email address: Preferred phone for contact? cell home work

Referred by: Primary Care Doctor:

Marital Status: [ ] Single [ ] Separated [ ] Divorced [ ] Married [ ] Widowed [ ] Other

Work Status: [ ] Retired [ ] Full-time student [ ] Unemployed [ ] Disabled

[ ] Part-time employed [ ] Full-time employed → Occupation:

Employer:

Were you injured while working? (Worker's Comp) [ ] Yes Date of Injury: [ ] No

Were you injured in a car accident? [ ] Yes Date of Injury: [ ] No

Are you represented by an attorney? [ ] Yes Name of attorney: [ ] No

Insurance Information:

Primary Carrier:

Name: _____

Patient's Relationship to Insured:
□ Self □ Spouse □ Child □ Other _____

Secondary Carrier:

Name: _____

Patient's Relationship to Insured:
□ Self □ Spouse □ Child □ Other _____

Emergency Contact:

Contact Name: _____ Relationship to Patient: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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Consent for In-Patient Neuropsychological Services

This Consent for In-Person Neuropsychological Services is a supplement to the general informed consent. Please read this document carefully and let us know if you have any questions.

As you know, the threat of COVID-19 is ongoing in the United States. The decision about whether to engage in in-person services at any point is based on current conditions and guidelines. Comprehensive neuropsychology evaluations require face-to-face contact with the patient, and we are slowly opening our in-person clinic, based on guidelines and regulations established by the CDC, the American Psychological Association, the National Academy of Neuropsychology, and the State of Hawaii.

We have worked diligently to create policies and procedures that must be followed in order to further promote the health and safety of our patients and staff. Your well-being is our top priority!

- Screening of all persons entering the office.
- All staff and patients are required to wear a mask while in common areas of our clinic.
- Hand sanitizers containing at least 60% alcohol will be available in the waiting room and the testing rooms. Upon arrival please use the hand sanitizer, or wash your hands, and use at other times during your stay.
- Staff will disinfect all surfaces and examination equipment after every patient encounter.
- Plexiglass shields are installed where necessary. Air purifiers and filters will be used.
- Reduced patient volume per day, and thus fewer people in our clinic at one time.
- Maximizing social distancing, with minimal use of the waiting room. Please do not move chairs or otherwise decrease social distancing. Patients may need to wait downstairs, or in their cars.
- **Only one person should accompany you to your visit**. If applicable, family members and friends should wait in their cars, or return home after speaking to the doctor.
- When possible, we will send you registration documents via encrypted email and will ask you to return completed documents either scanned to email, or to hand carry on the day of your appointment. We may also ask you to forward a copy of your driver's license and insurance card via the encrypted email message link or hand carry them to the office on the day of your appointment.
- Telemedicine visits are also available for feedback appointments if you prefer. Most insurance plans cover these virtual visits.

To keep everyone safe, you agree to follow all protocols and to refrain from visiting our clinic if:

- You or a household member have symptoms of COVID-19 (symptom list on following page).

- You have been around someone with known COVID-19 in the last 14 days.

- You or someone with whom you live recently traveled to a COVID-19 “hot spot” (such as California, Florida, New York).

If you come to an appointment with symptoms or you have been exposed to the virus, we will require you to leave the office immediately, but we can reschedule you for a later date. If we or any of our staff have symptoms or test positive for the coronavirus we will notify you so that you can take appropriate precautions, and we will reschedule you or you can be referred to another qualified practitioner.

Informed Consent

We are committed to keeping you, our staff, and all of our families safe from the spread of this virus. Your signature indicates that you understand the risks associated with face-to-face contact, and that you agree to abide by the practices set forth for preventing infection. By signing this consent form, you assume any, and all, medical risks and damages associated with contracting the COVID-19 virus. You are agreeing to not hold Dr. Spina responsible for any consequences of contracting COVID-19 virus. You acknowledge that you understand that there is still a potential risk of exposure and that you agree to follow the safety protocols outlined above in order to engage in in-patient services.

_____ _____

Patient Date Signed

_____ _____

Laila Spina, Psy.D. Date Signed