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

Consent For Neuropsychological Interview/Evaluation

I understand that the purpose of this evaluation is to provide information about me for my physician or other health care provider who has requested the evaluation in order to assist in their diagnosis and treatment of me. The material from the interview(s) and neuropsychological testing will result in the generation of a report that will provide information related to diagnosis and treatment of me. The report generated by Dr. Spina will be sent to my physician or other health care provider and Dr. Spina may also discuss the results of the evaluation with them. If desired by me or my referring provider, Dr. Spina will also discuss the results with me and any others which I so designate by signing a release of information allowing Dr. Spina to do so. If this evaluation is being covered or partially covered by my insurance, Dr. Spina may be required to provide the insurance company with a report as well.

Dr. Spina's questions may touch on personal and private matters that could cause me emotional discomfort and revive painful memories. I recognize that Dr. Spina has no intention of causing any personal discomfort but that she is simply carrying out her professional task associated with this evaluation. Even though some of the subjects under discussion may not appear at first glance to have a direct connection with this issue at hand, I will cooperate to the best of my ability. I understand that although I am expected to give honest and accurate answers, I am free to refuse to answer any question I choose or to terminate the evaluation whenever I wish.

Dr. Spina is required to notify authorities if she knows of or suspects that a child is abused or if she has reason to believe that I may harm others or myself.

The terms of this evaluation had been reviewed, understood and agreed to by me.

Sign: _____ Date: _____

_____
(Please Print Name)

Guardian: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: _____

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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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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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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Full Name) (Date of Birth)
hereby authorize the release of my health information

From: Dr. Laila Spina
To: _____
_____
_____
_____
_____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: _____
Information requested: _____

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire one year after the date signed. The requestor should not redisclose my medical record to another party without further written consent. I will not hold Dr. Laila Spina nor Pacific Neuropsychology Services liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Laila Spina for clarification of the information therein.

Date: _____ Signature: _____
(Patient or Legal Representative)

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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