Dr. Moldover & Associates

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Wellesley, MA 02482

781-237-1735
781-237-1768 (fax)
info@drmoldover.com

www.drmoldover.com

Thank you for contacting our practice. Below, you will find a number of forms which need to be filled out in advance of your upcoming appointment. These include a child development questionnaire; an agreement for psychological services; a financial agreement; and information on the management of confidential health information.

The office is located on the second floor of 555 Washington Street in suite #5. Parking is on-street, or in a municipal lot across the street. Spaces are metered.

Please note that the office is on the second floor and the building has no elevator. If you have mobility concerns, please contact us ahead of time.

In the time leading up to your appointment you may have additional questions. Please feel free to contact us at 781-237-1735, or to email at info@drmoldover.com. Information is also available at www.drmoldover.com.

We look forward to working with you and your family.

Child Developmental History

A. Identifications

1. Child's full name: Birthdate:

Person(s) completing this form:

Today's date:

2. Parent One: Birthdate:

Home phone: Address:

Occupation:

Work phone:

Cell Phone:

Email:

Highest level of education:

3. Parent Two: Birthdate:

Home phone: Address:

Occupation:

Work phone:

Cell Phone:

Email:

Highest level of education:

4. Parents are currently: Married Divorced Seperated Never Married

Child's custodian/guardian is:

Please note: if parents are not married, complete attached child custody form.

5. Step-parent's name, if applicable:

6. Other family members (please include ages):

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7. Is there any known family history of learning, developmental, neurological, or psychiatric disorder? (please specify):

B. Development

Please fill in any information you have on the areas listed below.

1. *Pregnancy and delivery*:

Prenatal medical illnesses and health care:

Was the child premature? No Yes. Weight and height at birth:

Any birth complications or problems?

2. *The first few months of life*:

Sleep patterns or problems:

Temperament & Personality as an infant (i.e., "easy"; "difficult to soothe", etc):

3. *Milestones: At what age did this child do each of these*?

Sat without support: _______________

Crawled: _________________

Walked without holding on: ______________

Age when child said first word understandable to a stranger: _____________

Age when child said first sentence understandable to a stranger: _____________

Any speech, hearing, or language difficulties?

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C. Health

List all *childhood illnesses, hospitalizations, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions*.

Condition	Age	Treated by whom?

Name of Primary Care Clinician (i.e., pediatrician):

Is the child currently prescribed any medications? (if so, please list name, dosage, and prescribing clinician):

D. Residences

Dates		
From	To	Location

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E. Schools

School (name, district, address, phone) Grade /Age

F. What are your child's strengths? Does he/she have any special skills or talents?

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.:

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

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Child Custody Declaration

To be completed in instances in which parents are divorced, separated, or never married; or in which care is being sought for a foster child.

I hereby attest that I am the legal guardian of the child ______________________ ________(date of birth___________), and am thereby empowered to make all decisions pertaining to this child's health and educational needs, including the provision of psychological and neuropsychological services. In addition, I attest that no court order or custodial agreement limits my powers in this regard or requires additional consent from another party.

Name (printed)   Date

Signature

In the space below, please provide the name, address, and telephone number of parents/guardians residing elsewhere:

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Consent and Agreement for Psychological Testing and Evaluation

I, ____, agree the psychologist assigned to me through Dr. Moldover and Associates, and those assisting him/her, to perform an evaluation, including neuropsychological, psychological, and educational testing as well as report preparation and consultation with other members of the clinical team for the purpose of coordinating care.

In addition, I wish to authorize the following:

❑ Consultation with school personnel
❑ Consultation with lawyers /advocates
❑ Other (describe):

____

This agreement concerns ❑ myself or ❑ ______________________________________

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, and any other activities to support these services. If I have questions or concerns about this assessment, the evaluator agrees to be available to discuss these after completion of the testing and interviews.

Signature of client (or parent/guardian) Date

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Notice of Privacy Practices

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of a full, legally required notice of privacy practices, which is available upon request.

How we use and disclose your protected health information with your consent
We will use the information we collect mainly to provide you/your child with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

At times professionals outside of our practice may access information for the purpose of business/administration functions. Examples include accountants and book keepers who access our records. These individuals will have signed contracts with our office requiring that they keep any information that they access confidential.

Disclosing your health information without your consent
There are some times when the laws require us to use or share your information. For example:
1. When there is a serious threat to your/your child's or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are mandated to report child abuse or neglect or elder abuse or neglect.
3. When we are required to do so by lawsuits and other legal or court proceedings.
4. If a law enforcement official requires us to do so.
5. For workers' compensation and similar benefit programs.
6. When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the HIPAA Privacy Rule and the Commonwealth of Massachusett's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Your rights regarding your health information
1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work,

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to schedule or cancel an appointment.
2. You can ask us to limit what we tell people involved in your care or the payment for your/your child's care, such as family members and friends.
3. You have the right to look at the health information we have about you/your child, such as your medical and billing records. You can get a copy of these records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing. You must also tell us the reasons you want to make the changes.
5. You have a right to restrict disclosures when you have paid for your care out-of-pocket (i.e., you have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services).
6. You have the right to a copy of this notice.
7. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact us directly at 781-237-1735.

You have a right to be notified if there is a breach of your unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

1. When the Practice becomes aware of or suspects a security breach the practice will conduct a Risk Assessment. The Practice will keep a written record of that Risk Assessment.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach within 60 days of discovery.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

The effective date of this notice is September 23, 2003.

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, when we use the words "you" and "your" below, this can mean you or your child. When we examine, test, diagnose, treat,

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or refer you/your child, we will be collecting what the law calls “protected health information” (PHI). We need to use this information in our office to decide on what treatment is best for you/your child. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you/your child. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing.

If you do not sign this form agreeing to our privacy practices, we cannot treat you/your child. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 781-237-1735.

Please note: if you ask us to consult with other caregivers or with educators regarding your child, this request will release us to share information pertinent to the consultation.

Electronic communication: at times, you may wish to communicate with this office via email. Please note that this is not necessarily a secure means of communication.

Signature of client or his or her personal representative Date

Printed name of client or personal representative Relationship to client

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Financial Policies and Statement

We are not contracted providers for any health insurer. Payment for services is due in the amount and on the schedule agreed upon with your clinician prior to the start of assessment.

We are able to provide receipt for services with applicable clinical and diagnostic codes, and your health insurer may offer you some reimbursement, however:

- Some insurance plans do not offer reimbursement for out-of-network services
- A developmental neuropsychological evaluation consists of both clinical and educational components. Clinical components include neuropsychological assessment of neurologically based psychological functions such as memory and language. Educational components include assessment of academic skills using standardized tests, review of educational records, consultation with the teacher and school, and development and discussion of educational recommendations. Health insurers <u>may</u> provide coverage for clinical evaluation, but as a matter of policy do not cover educational services.
- In some cases health insurers deem part or all of the clinical portion of the evaluation to be not medically necessary.

Your signature below indicates that you understand and consent to these policies.

Name (printed)   Date

Name (signature)

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INFORMED CONSENT FOR TELEPSYCHOLOGY

Some or all of your child's evaluation may take place via telepsychology. Use of telepsychology will vary from one evaluation to another, based on the needs of the child, the purpose of evaluation, and technological variables. Your clinician will discuss use of telepsychology (including technical and environmental requirements) with you prior to the beginning of your child's evaluation. This Informed Consent for Telepsychology contains important information focusing on doing telepsychology using the phone or the Internet.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy or assessment-based services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychology and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of our office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end, we will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in telepsychology only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Efficacy. Most research shows that telepsychology is about as effective as in-person psychological services. However, some clinicians believe that something is lost by not being in the same room. For example, there is debate about a clinician's ability to fully understand non-verbal information when working remotely.
- Testing. Most psychological, neuropsychological, and educational tests have been developed and standardized for in-person use. Research on remote application is ongoing, but at present varies from one instrument to another. Your child's clinician will make every effort to use remote testing in the most valid and reliable manner possible, however in some cases this represents a departure from test standardization and may impact conclusions derived from those tests as well

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as the use of these tests in educational or legal settings. You should discuss the specifics of your child's battery with your clinician.

Confidentiality

We have a legal and ethical responsibility to make our best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private and will not record any telepsychology sessions without previous written consent; however, there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology). The extent of confidentiality and the exceptions to confidentiality that we outlined in our Informed Consent still apply in telepsychology. Please let us know if you have any questions about exceptions to confidentiality.

Please note: test materials are copywritten by test publishers, and it is expressly forbidden for you or your child to save, print, record, photograph, or otherwise preserve materials used in tele-assessment.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

SIGNATURE

Date

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our mutual decision to participate in in-person services in light of the COVID-19 public health crisis. Please read this carefully and contact our office if you have any questions.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future services. You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your clinician will make every effort to maintain physical distancing during your time in the office. However, the administration of certain tests requires that the clinician sit at a table (within six feet) of a child. As noted below, in accord with requirements set forth by the Town of Wellesley we require that all visitors to our office wear masks (including children during testing). Staff also must wear masks.

In addition, during in-office testing, the clinician may decide to administer some measures remotely. This will entail interacting with your child from another room using a monitor and intercom. Decisions about inter-room administration will be made on the basis of a child's developmental and emotional needs, and will be discussed with you ahead of your visit.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure, sickness and possible death.

We understand that children vary in their developmental preparedness for participation in pre-cautionary measures. We are committed to working with every child and family in the safest manner possible; please speak with your clinician before your appointment with regard to any concerns you have regarding masks, physical distancing, etc.

Please initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you and your child are symptom free. ___
- You will take your and your child's temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. THERE IS NO CANCELLATION FEE. __

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- You and your child will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wait in your car while your child participates in testing. Should your child require you close at hand during testing, please inform us and alternate arrangements will be made. ________
- You and your child will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You and your child will adhere to the safe distancing precautions we have set up in the waiting room and testing room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You and your child will wear a mask in all areas of the office ___
- There will be no physical contact (e.g. no shaking hands) with staff. ___
- You and your child will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let our staff know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let our staff know. ___
- If a resident of your home tests positive for the infection, you will immediately let our staff know.___

We may change the above precautions if additional local, state or federal orders or guidelines are published.

Our Commitment to Minimize Exposure
Our practice has taken steps to reduce the risk of spreading the coronavirus within the office. Please let us know if you have questions about these efforts. If anyone on our staff tests positive for the coronavirus, we will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you or your child have tested positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that we may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreements for our practice.

Your signature below shows that you agree to these terms and conditions.

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Parent/guardian signature (or client, if 18 or over)

Date

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