APRIL R. HOLMAN, Ph.D.
CONSENT TO TREAT and DISCLOSURE STATEMENT

Patient's Name: ______________________________ DOB: ____________________

Welcome to my practice. This document contains important information about my services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us. Please do not hesitate to discuss any questions you might have about this form.

Patients and legal guardians consent to receive assessment and treatment services from April R. Holman, Ph.D. Patients and legal guardians consent to enter into the following understanding:

1. Patients will be administered diagnostic and treatment procedures as recommended by Dr. Holman. Patients, or a parent or legal guardian in the case of a minor, must initial numbers 7 through 11 in the following in order to acknowledge payment responsibility. In the case of joint custody, both parents will need to initial, sign, and date this document. If both signatures are not present on this document your child cannot be seen.

2. The information provided during assessment and treatment services is confidential. Specific information is released to outside agencies or persons only after written consent of a parent(s) or legal guardian(s) is obtained. The only exceptions to confidentiality are as follows:

    - When a patient, family member of collateral person states an intention to seriously harm him/herself or, harm another person(s). Dr. Holman has the legal obligation to warn the individual's family, intended victim, and/or the police.
    - When there is reason to believe there is abuse or neglect of a child or vulnerable adult. The law requires a report be made to the police or other appropriate county agency.
    - When an emergency condition occurs, Dr. Holman will communicate with a family member or other appropriate person.
    - By court order.
    - When a joint custodial parent requests information about their child. Information that is not necessary to the assessment or treatment of the child will remain confidential in regard to the other (custodial) parent.

3. A minor has the right to request private data be kept from their parents or legal guardian. This request will be honored by Dr. Holman if it is believed to protect a child from physical or psychological harm, or if confidentiality is in the best interest of the child. However, parents and legal guardians have a right to information regarding their child, and efforts will be made to engage families as partners in assessment and treatment services.

4. If any child is the subject of a court order, settlement or custody agreement, the parents or guardians must furnish Dr. Holman with a copy of the order or agreement by the parent or guardian who has been awarded or granted legal custody of the child. If two separate or divorced parents share legal custody, or if two guardians are appointed by a court, then all requests for information or all consents for treatment, or a plan for treatment must be approved by both parents with legal custody or both guardians appointed by the courts. The person or party who has obtained or agreed to the custody modification or change shall furnish Dr. Holman with any modification or change of legal custody or guardianship of the child. A child will not be seen unless this information is provided. Any information relevant to the child's assessment or treatment learned during a child's treatment may be included in reports and medical records.

5. Individuals and families have the right to access clinical information. You may request an information review with Dr. Holman. However, in certain circumstances, if Dr. Holman determines that reviewing such information may be deemed harmful, she may instead provide a summary of the clinical information.

Alternatively, an outside therapist can be requested by a parent/guardian to interpret the information after a specific release of information is obtained. Copies of medical records can be requested at an additional expense.

6. Dr. Holman may recommend neuropsychological testing, including intelligence testing. Intelligence tests provide valuable information in regard to intellectual strengths and weaknesses. This shall be interpreted in the context of a child's sociocultural and individual uniqueness to minimize biases and limitations inherent in any standardized testing.

Please read and initial statements 7 through 11.

_______ 7. The hourly rate is for evaluation sessions, for therapy. In addition to face-to-face appointments, this amount is charged for other professional services you may need, though the hourly cost will be broken down for work periods of less than one hour. Other services include scoring and interpretation, report writing, school observation, attending school meetings, preparation of records or treatment summaries, telephone conversations, and time spent performing any other service you request. Fees are expected to be paid as follows: Half of the evaluation fee should be paid at the session, and the remaining at the time of the Finding and Treatment Recommendation session. Treatment sessions are to be paid at the time of service.

_______ 8. This office does no bill insurance. You will be provided with a statement that can be submitted to your insurance company for reimbursement. Without explicit authorization, Dr. Holman will not communicate with your insurance company, as that would entail transmission of confidential diagnostic information. Dr. Holman will not accept assignment of payment and does not in any way guarantee insurance eligibility, authorization or level of reimbursement. You are personally responsible for the cost of any services incurred with Dr. Holman.

______ 9. Dr. Holman extends as a courtesy to her patients and their families the ability to pay for services by the end of the month in which the services have been rendered.

Effective March 1st, 2012, Dr. Holman will assess the following scheduled fees for late payments:

- Payments received from the 11th-20th of the month following the rendering of services will incur a late payment penalty of 10% of the balance due.

- Payments received from the 21st-30th of the month following rendering of services will incur a late payment penalty of 20% of the balance due, per month until reconciled.

- After 30 days, Dr. Holman will transition patients unable to pay their bills to treatment facilities offering sliding scale fees.

To avoid late fees it is recommended by Dr. Holman that patients pay for individual sessions at the time services are rendered or request their current balance at month's end and pay by this time.

______ 10. Scheduled appointments require a 48-hour cancellation notice. If notice is not received for a service, you will be billed at the hourly rate. It is the client's responsibility to be on time for each and every appointment or session. If a patient arrives late for any appointment or session, the appointment or session will end at the appointed time.

_______ 11. If you are to become involved in legal litigation and I become involved as a result, you agree to pay for all my time including but not limited to record retrieval, record review, preparation for depositions and court appearances, and my appearance in court proceedings. My fee is double my usual and customary hourly fee at time of legal litigation.

12. In treating a child, in case of an emergency, when it is the opinion of Dr. Holman that a child be seen by a physician, and it is not possible to reach parents or legal guardians, or the child's primary care physician, an emergency arrangement will be initiated by Dr. Holman for the child to receive treatment.

Primary Care Physician:

Name ______________________

Address, Phone ______________________

Health Agency Name ______________________

Emergency Contact:

Name ______________________

Address, Phone ______________________

Relationship to Child ______________________

By signing below, I agree to the terms and conditions outlined above and authorize Dr. Holman to provide assessment and treatment services to me, my child, and/or family. I also agree to be financially responsible for those services.

Patient's Name: ______________________
(Please print)

Parent/Guardian: ______________________ Date: __________
(Signature)

Parent/Guardian: ______________________ Date: __________
(Signature)