RICHARD D. BACK, PH.D.
CLINICAL NEUROPSYCHOLOGIST
1706 JOYCE, SUITE 3
FAYETTEVILLE, AR 72703
(479) 442-9381 (OFFICE) (479) 442-9396 (FAX)

FEE AGREEMENT

I am voluntarily seeking the psychological services of Dr. Richard D. Back, Ph.D.

I understand that the following fees apply:

$280.00	Initial Session/Evaluation (with billed insurance)
$150.00	Initial Session/Evaluation (cash discount, no insurance)
$190.00	Psychotherapy Sessions (with billed insurance)
$100.00	Psychotherapy Sessions (cash discount, no insurance)
$ 50.00	**Psychotherapy Sessions that are scheduled but not attended and not cancelled at least 24 hours in advance**
$ 20.00	Telephone consultation during office hours

Fees may be lower if Dr. Back has a previous agreement with my insurance company to accept a lower rate. I understand that I am responsible for payment of all fees, whether or not my insurance covers them. I understand that my insurance company may require me to pay a deductible each year and perhaps a percentage of the charges for each session. My insurance company can provide me with information about my deductible and co-pay at any time. I accept that it is my responsibility to understand my own insurance policy, to understand what is and is not covered, and to get authorization for treatment in advance if it is required.

I understand that any fees due will be paid at the time of the session. Payment plans may be agreed upon in advance between the patient and Dr. Back. **This office does not accept debit or credit cards.**

I understand that if I fall 60 days in arrears without making prior arrangements for payment with Dr. Back, he may seek payment through legal means, which may include small claims court or collection agencies. If this is necessary, I agree he may break confidentiality only to the extent of releasing my name, nature of services provided and amount due. I also agree to be responsible for any collection fees that are incurred.

_____ _____

Name of Patient/Responsible Party Date

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AGREEMENT FOR TREATMENT

I agree to seek the psychological services of Dr. Richard D. Back, Ph.D. for myself and/or for children of whom I am the legal guardian.

I understand that all appointment times are reserved for me. If I need to cancel or reschedule, I will do so at least 24 hours in advance unless it is due to emergency circumstances. I understand that **failure to provide 24 hours notice of cancellation or failing to show up for a scheduled appointment will result in charges for the time reserved.**

I understand that all information provided is protected by confidentiality privileges. Dr. Back cannot release information without my prior approval unless it involves child abuse, intent to harm myself, or intent to harm others.

Date_____

Name_____Age_____Sex_____

Social Security No._____DOB_____

Home Address_____

Mailing Address (if different)_____

City_____State_____Zip Code_____

Home Phone_____Cell Phone_____

May we contact you at work?_____May we leave a message?_____

Emergency Contact Name_____Relationship_____

Emergency Number_____Referred By_____

If you wish us to file insurance for you, the following must be filled out completely and we will need to copy your insurance card(s):

Insurance
Company_____

Insured's Name_____

Insured's DOB_____Insured's SSN_____

Patient's Relationship to Insured_____

Identification No._____Group No._____

Insured's Employer_____

_____ _____
Patient Signature Date

HIPPA Packet Received (please initial)_____

HIPPA

Notice of Health Information Privacy Practices

This notice describes how health information about you may be used or disclosed by Northwest Arkansas Psychological Group and how to access this information.

Effective Date: April 14th, 2003

If you have any questions about this notice, please contact our office at (479) 442-9381.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We will create a record of the care and services you receive from us. We do so to provide you with quality care and to comply with any legal or regulatory requirements.

This Notice applies to all of the records generated or received by Northwest Arkansas Psychological Group, whether we documented the health information, or another doctor forwarded it to us. This Notice will tell you the ways in which we *may* use or disclose health information about you. This Notice also describes your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

Our pledge regarding your health information is backed-up by Federal law. The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA") require us to:

- Make sure that health information that identifies you is kept private;
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted each of these uses and disclosures may be made without your permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask for a separate authorization, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with healthcare treatment and services. We may disclose health information about you to doctors, nurses, technicians, health students, volunteers or other personnel who are involved in taking care of you. They may work at our offices, at a hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for consultation, to perform tests, to have prescriptions filled, or for other treatment purposes. We may provide that information to a physician treating you at another institution.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, a state Medicare agency, or a third party. For example, we may need to give your health insurance plan information about your diagnosis so your health plan will pay us or reimburse you for the visit. Alternatively, we may need to give your health information to the state Medicare agency so that we may be reimbursed for providing services to you. In some instances, we may need to tell your health plan about a service you are going to receive to obtain prior approval or to determine whether your plan will cover the service.

For Healthcare Operations: We may use and disclose health information about you for operations of our healthcare practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study healthcare delivery without learning who our specific patients are.

For Appointment Reminders: We may use and disclose health information about you to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

Research: There may be situations where we want to use and disclose health information about you for research purposes. For example, a research project may involve comparing the efficacy of one medication over another. For any research project that uses your health information, we will either obtain an authorization from you or ask an Institutional Review or Privacy Board to waive the requirement to obtain authorization from you. A waiver of authorization will be based upon assurances from a review board that the researchers will adequately protect your health information.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Prevent a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or are separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to an order issued by a court or administrative tribunal. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested, or unless you have signed an authorization permitting the disclosure.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- If you are the victim of a crime and we are unable to obtain your consent;
- About a death we believe may be the result of criminal conduct;
- In an instance of criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Such releases of information will be made only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary:

- For the institution to provide you with healthcare;
- To protect your health and safety or the health and safety of others; or
- For the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have certain rights to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. ***This does not include psychotherapy notes.***

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing on a form provided by us to "The Privacy Official at Northwest Arkansas Psychological Group." If you request a copy of your health information, we may charge a fee for the costs of locating, copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may in certain instances request that the denial be reviewed. Another licensed healthcare professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing on a form provided by us and submitted to: "The Privacy Official at Northwest Arkansas Psychological Group."

We may deny your request for an amendment if it is not the form provided by us and does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list (accounting) of any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request on a form that we will provide to you. Your request must state a time period that may not be longer than six years and may not include dates before April 14th, 2003 [The compliance date of the Privacy Regulation]. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date should not exceed a total of 60 days from the date you made the request. You may withdraw or modify your request at any time.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example, you

could ask that access to your health information be denied to a particular member of our workforce who is known to you personally. *While we will try to accommodate your request for restrictions, we are not required to do so if* it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request on a form that we will provide you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your health information. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice at any time upon request. You may also obtain a copy of this Notice at our website, if and when one exists.

CHANGES TO THIS NOTCE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facility. The Notice contains the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact "The Privacy Official at Northwest Arkansas Psychological Group." All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.

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MISSED APPOINTMENT POLICY

Missed appointments will be charged $50.00. Missed appointments and appointments that are cancelled less than 24 hours in advance will both accrue the missed appointment charge.

Missed and late-cancelled appointments cannot be charged to insurance, which only pays for services provided. This mean YOU WILL HAVE TO PAY THIS FROM YOUR OWN FUNDS. Please discuss any questions about this policy with Dr. Back.

My signature below confirms that I have reviewed and been offered a copy of this policy.

_____ _____

Patient Signature Date

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CONSENT TO USE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I understand as part of my healthcare, Dr. Richard Back creates, receives, and maintains records describing my history, symptoms, evaluation, test results, diagnoses, treatment, and plans for future care or treatment. According to the new federal HIPPA regulations, I understand my health information may be used or disclosed to carry out my care and treatment, to obtain payment, and for health care operations.

I have received a copy of Dr. Back's Notice of Health Information Privacy Practices that provides a more complete description of information uses and disclosures and had an opportunity to ask questions about anything I did not understand. I understand Dr. Back has the right to change the privacy practices described in the Notice of Health Information Privacy Practices. If any changes are made, I understand Dr. Back will post/provide a cop of any revisions or I will receive a copy of the update Notice at my request.

I understand I have the right to request restrictions on how this office uses and discloses my information for treatment, payment, and health care operations. This request must be submitted in writing to this office. I understand this office is not required to agree to the restrictions requested, although they are bound to adhere to my request for restrictions if they agree. I understand I can revoke this consent at any time, in writing, except to the extent any action that has already been taken in reliance on my consent.

My signature below serves as an acknowledgment that I have received a copy of the Notice of Health Information Privacy Practices, as well as consent for the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

_____	_____	_____
Printed Patient Name	Signature of Patient	Date

_____	_____	_____
Printed Name of Witness	Signature of Witness	Date