Theresa Lavoie, Ph.D.
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Clinical Neuropsychologist
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General Information

Today's Date: ____________________

Client Name:____DOB:___________________Age: _________________

Address:_______________________________________City/State:______________________ Zip:________________

Mobile Phone:_______________________________________Whose # ? ____________________________________

Alternate Phone:____________________________________Whose #? ______________________________________

Email: ____

Is it okay to add your email address to a limited use confidential email list for matters related to my private practice and professional work? Yes/ No

Is it okay to call, text, email or leave message regarding appts? Yes/ No

Last Grade Completed:_________________School:____

How did you hear about my services?:____

Parents names if adolescent is being seen:____

Health Insurance Portability and Accountability Act (HIPAA)

By signing this document, I acknowledge that I was given the HIPAA Client Services Agreement that explains the privacy protection, use, and disclosure of personal information (Protected Health Information (PHI)). I acknowledge that I have reviewed and understand these policies.

Payment Information

Credit Card #:____Exp Date:_____________CVV: _____

Type (circle): Visa /MC/Amex Name on Card:____

I give permission to maintain this credit card on file and for Dr. Lavoie to process all future charges using this credit card.

Signature:____Date: ____________________

Payment Policies

General Information

I want to provide the highest quality of service and have found the only way I can do this is to not contract with insurance companies. I do wish this were different and apologize for any difficulties this may cause. I am committed to providing the best possible treatment, free of managed care and insurance restrictions. Because of this, services are provided on a private-pay basis only and are collected at the time of service. I hope that it is helpful that I am able to accept cash, checks, credit cards, Venmo and health service accounts as payment. If you seek reimbursement from your insurance company, I can assist by providing a statement of services, dates, charges, procedures and diagnostic codes.

Rates for clinical services listed below are available for your convenience in person, video-conference or phone.

- 45-50 Minute Individual Therapy Session (In person or remote): $225
- 80 Minute Initial Intake & Record Review (First Session): $375
- Neuropsychological Evaluation: $4500 (Includes initial intake, all testing and assessments regardless of how much time is required, comprehensive report meeting gold standard requirements and feedback session.)
- Hourly Testing/Assessment Rate: $300
- Consultation, Second Opinion and Team Meetings: $225 per hour

Missed Appointments and Cancellations

Your appointment time is reserved just for you. Please let me know as soon as you can if you need to reschedule so I can offer the time to someone else. If you let me know at least 24 hours ahead of time, you can avoid the $225 missed appointment fee. Illness or emergencies are, of course, exceptions. Also, if the appointment time can be filled by another client on short notice, you will not be charged the fee.

Legal Testimony/Report Writing

Sometimes during the course of our work together you may request a letter or report to a third party for legal purposes, or request that depositions or legal expert witness testimony be provided. If together we determined it is in your best interest, I am happy to proceed with your written consent. These services are $400 per hour (including travel time) plus expenses, which we would discuss in advance.

I have read, understand and agree to abide by the policies as written above.

____________________	____________________	_______________
Print Name	Signature	Date

ELECTRONIC COMMUNICATION POLICY

Since various types of electronic communications is common in our society and many individuals believe this is the preferred method of communication with others. However, many of these common modes of communication put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to address the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. If you have any questions about this policy, please discuss this with me.

Email/Text Communications: Email communication and text messaging will be used only with your permission and only for administrative purposes. Clinical information will not be included in these forms of communication.

Social Media: I do not communicate with, or contact, any of my clients through social media platforms. If I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

Web Searches: I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals, much of which may actually be known to that person and some of which may be inaccurate or unknown. Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me, please share it with me so we can discuss it and its potential impact on your therapy.

CLIENT SERVICES/HIPPA AGREEMENT

This document contains important information about processional policies regarding privacy protection, use, and disclosure of your Protected Health Information (PHI). These policies are in accord with the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, I am required to provide you with this information and obtain your signature acknowledging we have provided you with this information. By signing your Client Information Form, you acknowledge having received this information.

Limits on Confidentiality
The law protects the privacy and confidentiality of all communication between a client and the client's clinician's. In most circumstances we can release information about you (or your child) only with your written authorization. There are a few exceptions to confidentiality and situations in which information may be released without authorization or consent. Parents hold confidentiality rights of children under the age of 18 who are not emancipated. For the sake of clarity, "you" also refers to your child if you are here receiving services for your child. In divorce situations, both parents have equal access to their client's records, even if one parent has sole legal custody.

Under HIPAA, use of disclosure of your PHI for the purposes of treatment, payment, or health care operations, requires your consent. Your signature on the client registration form provides consent for those situations. Treatment refers to services we provide which may include eliciting personal information from you or about you through interview, testing, documentation, or consultation with other clinicians intended to serve your health care needs. We are mandated by law to report to the appropriate agencies suspected neglect or abuse of children under age 18, individuals with mental or physical disabilities, or elders. We may be required to provide additional information once making such a report. If you (or your child) appear to be at clear or immediate risk of self-harm or harming an identified person, we must take reasonable precautions to insure safety. These precautions may include warning a potential victim, notification of law enforcement, or arranging for hospitalization. These precautions may involve disclosure of PHI without your consent or authorization, which is permitted under the law in these circumstances. If you file a Worker's Compensation claim, your records relevant to that claim can be requested and provided to your employer, insurer, or the Department of Worker's Compensation. If you are involved in court proceedings, unless there is a court order, your written authorization is required from you or your legal representative in order for us to release information.

Client Rights and Clinician's Duties
You have the right to request restrictions on the disclosure of your PHI. We are not required to agree to a restriction you request but will make every effort to do so, within the legal limits and exceptions of confidentiality. You have the right to request the location at which you receive communications involving PHI, as in an alternative address or phone number. You have the right to request in writing to examine and/or receive a copy of your records, unless we determine that access would be a danger to you. In that situation, you have the right to a summary of the record and you can request that your record be sent to another mental health provider or to your attorney. You have the right to request an amendment to your record. We may deny your request, but can document your concerns in the record.