

SHIRO PERERA TORQUATO, PH.D.

Licensed Clinical Psychologist

License # PSY14840

Phone and Fax (805) 527-4146

This cover letter is to inform you about the federally mandated forms that are being used by all health-care providers, beginning on 4/14/03. These forms are intended to provide you with information about privacy practices related to your health-care information. Please read these forms carefully and sign where indicated. I have also enclosed a few other short consent forms for you to complete. Please bring all of this paperwork to your first appointment at **1633 Erringer Rd. Suite 204 (cross street Heywood).**

If you have any questions or concerns, please feel free to call me at the above phone number or we can discuss it when we meet. Thank you for taking the time to review these forms and sign them prior to our first appointment. Also, please bring your child's most recent report card (if applicable). I look forward to meeting you.

Sincerely,

Shiro Perera Torquato, Ph.D.
Licensed Clinical Psychologist

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License # PSY14840
1409 Kuehner Dr. #239
Simi Valley, CA 93063
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**CONSENT FOR SERVICES
CONTRACT FOR
PSYCHOLOGICAL ASSESSMENTS AND
EDUCATIONAL CONSULTATIONS**

The undersigned individual and/or responsible party voluntarily consents to and authorizes psychological services by Shiro Perera Torquato, Ph.D., hereinafter referred to as "the psychologist". The undersigned individual and/or responsible party also understands and agrees to the following:

1. CONFIDENTIALITY

By law you hold the privilege of confidentiality. This means that the psychologist is prohibited from revealing any information you have disclosed without your written permission. If you request that the psychologist communicate with another party, you will be asked to sign an Authorization to Disclose Protected Health Information form. However, there are circumstances under California law in which the psychologist is required to disclose information without your written permission. These include:

- a) If the psychologist is made aware of physical abuse, sexual abuse or severe emotional abuse of minors (under age 18) or elders (over age 65), she is obligated to report this information to the designated authorities.
- b) If the psychologist is made aware that you may be a danger to yourself, others or property, and if disclosure is necessary to prevent that danger, she is required to report this to the designated authorities and to warn any specific person to whom you may be a danger.
- c) If in a legal proceeding, you or your legal representative (i.e., attorney) raises the issue of your mental condition, then the psychologist's records or testimony can be subpoenaed and she is obligated to testify even without your permission.

2. STRUCTURE OF THE SESSIONS

PSYCHOLOGICAL ASSESSMENTS: A psychological assessment involves meeting individually with a child or adult and administering a series of tests to assess his or her cognitive abilities, academic skills and social and emotional functioning. This type of testing is useful in identifying learning disabilities, giftedness and specific behavioral and emotional problems. The time necessary to complete a psychological assessment varies considerably depending on the age of the client, the referral question(s) and the types of tests administered. During the initial appointment the format and time of the testing session(s) will be discussed and agreed upon. After the testing is completely administered, the results will be scored and interpreted. A written report and/or feedback session will also be completed, unless otherwise agreed upon.

EDUCATIONAL CONSULTATIONS: An educational consultation involves working with parents, teachers and school administrators to determine whether a child is in need of special education services or specific accommodations within the classroom. This may also involve reviewing previously administered testing and interpreting the findings for parents, as well as attending school meetings, if necessary. Additional psychological testing can be administered, if deemed necessary and appropriate. The time necessary to complete an educational consultation varies considerably depending on the age of the client, specific educational concerns and previously attempted interventions. Therefore, the format and time will be discussed and agreed upon when the initial appointment is made.

3. FINANCIAL TERMS AND INSURANCE COVERAGE

FEES: The fee for psychological assessments and educational consultations is \$145/hour. This includes initial interviews, test administration, scoring, interpretation, report writing and feedback sessions. This also includes consultations with other professionals/teachers on an as needed basis, with prior written permission, as well as attendance at school meetings (and travel time). Please note that the copay will be charged for the testing session time, as well as time required to complete scoring, interpretation and report writing, depending upon your benefits. Payment will be due at the end of each session(s) and prior to the release of the testing report. You will be provided with a superbill that lists all of the services and the time that was required to complete each service. Also, telephone calls that require more than 10 minutes may be billed at the prorated rate of \$145/hour. Please note that most insurance companies do not reimburse for telephone calls, so your insurance will not be billed. If more than 10 minutes is required to properly discuss an issue, an appointment can be made for an office visit/consultation, which is typically covered by insurance.

INSURANCE: Your insurance may cover some portion of your fee. If you are a Blue Cross of California member with full mental health benefits, your insurance will be billed directly by the psychologist, after any deductible and/or copay is met. There are a number of other insurance plans that utilize the provider panel of Blue Cross of California. If you have one of these plans, you will be billed at the Blue Cross of California rate, but will have to submit your superbill directly to your plan for reimbursement. If you have out-of-network benefits for mental health services with your insurance plan, the psychologist will provide you with a superbill containing all of the relevant information required to receive reimbursement from your insurance company. If for some reason your insurance does not/will not cover the psychologist's fee you understand and agree that you will be responsible for the fees for services. At any time during the assessment process should you become ineligible for insurance coverage, you will notify the psychologist and understand that you will become responsible for 100% of the bill.

BOUNCED CHECKS: Please note that there will be a \$25 charge for each returned/bounced check, and any future payments should be made in the form of cash or cashier's check.

DELINQUENT ACCOUNTS: You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agreed to pay interest at 1.5% per month. If it becomes necessary for the account to be referred for collection action, you shall pay the actual balance due and any collection expenses for 30 to 50% of any balance owing and any attorney's fees.

CANCELLATION AND MISSED APPOINTMENT POLICY: Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you may be billed according to the session fee. Your insurance company does not cover fees associated with missed or canceled appointments, So, you may be responsible for the entire fee if appointments are canceled without appropriate notice.

I have read and understand the above information and voluntarily agree to abide by the terms of this contract.

Name of Client

Signature of Client

Date

Signature of Responsible Party

Relationship to Client

Date

CLIENT DATA SHEET

Client's name: _____ Today's Date: _____

D.O.B.: _____ Age: _____ Grade: _____ School: _____

Address: _____ Home Phone: _____

Other Responsible Party (If applicable)

Parent/guardian's name: _____

Siblings:

Parent/guardian's work phone number: _____

Name: _____ Age: _____

Other parent/guardian's name: _____

Name: _____ Age: _____

Other parent/guardian's work phone number: _____

Name: _____ Age: _____

Primary Care Physician's name: _____

Primary Care Physician's Phone Number: _____

Referred By: _____

Insurance Information (If applicable)

Insurance Company: _____

Name of insured: _____

Birth date of insured: _____

Subscriber #: _____

Group #: _____

In case of an emergency, who should be notified:

Name: _____

Phone number: _____

Relationship: _____

If you would like to be placed on our newsletter

E-mailing list please provide your e-mail address.

**(This information will also be kept confidential and used o
for newsletters)**

E-Mail: _____

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Consent To Use And Disclose Your Health Information

This form is an agreement between you, _____ and Shiro Perera Torquato, Ph.D.

(Client or parent/guardian)

When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

(Client's name)

When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can get a copy from the website, www.svfamily.com, or by calling me at 805-527-4146.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative's authority

Date of NPP 4/15/03

Copy given to the client/parent/personal representative