

INFORMATION FOR PATIENTS REFERRED FOR
PRE-IMPLANTATION OR PRE-SURGICAL
PSYCHOLOGICAL EVALUATION

You have been referred to see Dr. Marilyn Jacobs for a consultation for "pre-implantation psychological evaluation".

The reason for this referral is that as medical and psychological science has advanced, physicians and psychologists have become aware of the emotional issues involved with patients who have chronic pain and/or a medical problem that requires implantation of a pain management device and/or surgical intervention. Studies have shown that many patients who have emotional disorder or symptoms at the time of such procedures will have better results if their emotional symptoms are first given attention by psychological treatment. Also, patients may benefit from discussing issues related to their medical condition as well as their thoughts about the proposed procedure with a psychologist.

The goal of a psychological evaluation is to ascertain if there are any issues that may interfere with the best outcome when a medical procedure as discussed about is being considered by your doctor and if you require additional psychological treatment. In this evaluation, you will be asked questions about yourself and your history as well as your current medical condition. It may be recommended that you have psychological testing. At the conclusion of the evaluation, a report will be prepared for your physician. Your physician will use the information from the report to determine the best course of medical treatment for you.

If at the end of the evaluation process, it is felt that psychological treatment is indicated, a suitable referral will be made for you.

**INFORMATION FOR PATIENTS REFERRED FOR
PSYCHOLOGICAL EVALUATION
AS PART OF CHRONIC PAIN MANAGEMENT**

Chronic pain is a very complex disease syndrome. People with a chronic pain diagnosis are emotionally affected. Emotional stress and/or psychological symptoms may occur with the constant strain of living with chronic pain.

In American medical care, it is the accepted standard that many patients with a chronic pain syndrome will be asked to have a consultation with a clinical psychologist. The reason for this evaluation is to help the physician better understand the full complexity of the chronic pain condition and how it has affected the patient. We now know that the mind and body are interconnected and emotional states can influence physical disease. There are many other treatments in addition to medical care that are helpful for pain patients to alleviate their suffering. A consultation with a psychologist is the first step in knowing what behavioral treatment might be useful for a particular patient. It also will help your doctor with medical decision-making as to your care.

Your physician has referred you to my office for a **Comprehensive Psychological Evaluation**. This evaluation will involve my asking you many questions about your medical history, your emotional functioning and your emotional reaction to your pain. At the end of the evaluation, I will provide you with a summary of my findings and my impression of your situation. I will also discuss with you my reasons for making a treatment recommendation. We will then decide together if you need psychological treatment and with whom. I view my contact with patients as a partnership and welcome your input in any way that you think I can better help you to manage your chronic pain condition.

As your physician has referred you to my office, I will need to prepare a dictated summary report to him/her for his further understanding of the best way to treat your pain disorder. I also may discuss the evaluation with your doctor to clarify any questions. I recognize the sensitive nature of confidential discussions by a patient with a clinical psychologist. Therefore, if there is anything that you tell me that you wish me not to include in my report to your doctor, please tell me. Also, please be advised that in preparing this report, I will use a dictation service. The person who does my transcriptions is bound by the rules of confidentiality in the State of California. Please do not hesitate to discuss these issues with me before we begin our interview today. I am especially interested if you have any concerns about the above. I am available to answer all of your questions and make any further needed explanations.

I have read and understand the above and am in agreement. I authorize Dr. Jacobs to communicate to my physician as she sees fit:

Signed:

(Print name)

Date: _____

Marilyn S. Jacobs, Ph.D., Psy.D.
Clinical Psychology/Psychoanalysis
921 Westwood Blvd., Suite 227
Los Angeles, CA 90024-2942

(310) 824-8910

REGISTRATION (please print)

Date: _____ Home Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Employed by: _____ Work Phone: _____

Social Security #: _____ Medicare Subscriber #: _____

Medical Insurance:

Name of Primary Insurer: _____

Address: _____

Telephone: _____

Group #: _____

Subscriber #: _____ Date of Birth: _____

Subscriber Name: _____

In Case of Emergency Contact: _____ Phone: _____

ASSIGNMENT and RELEASE:

I assign directly to Dr. Marilyn Jacobs all benefits for psychological treatment, if any. I hereby authorize Dr. Jacobs to release all information necessary to secure the payment of benefits. I authorize a copy of this authorization to be used in placed of the original.

Signature of Insured

Date

PAIN INVENTORY

Name:

Date:

Please rate your pain by circling the one number that is the level of your WORST pain:

1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that is the level of your LEAST pain:

1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that is the level of your AVERAGE pain:

1 2 3 4 5 6 7 8 9 10

Marilyn S. Jacobs, Ph.D.
921 Westwood Blvd., Suite 227
Los Angeles, CA 90024-2942

Telephone: (310) 824-8910

Fax: (310) 552-2151

Patient Name: _____

SSN: _____

INFORMATION CONCERNING PSYCHOLOGICAL TESTING

As a part of the psychological evaluation that I have provided to you today, I have determined that it would be beneficial for you to complete psychological testing. This testing will provide me with additional information concerning your mental state and emotional functioning and will assist me in making further treatment recommendations.

The psychological tests that you will complete are:

- xx___ **Beck Depression Inventory** xx___ **Beck Anxiety Inventory**
- ___ **Sentence Completion**
- xx___ **Millon Behavioral Medicine Diagnostic**
- xx___ **Millon Clinical Multiaxial Inventory III**
- ___ **Minnesota Multiphasic Personality Inventory – 2**
- ___ **Symptom Check List 90-R**
- xx___ **Problems Experiences Checklist**

This testing consists of questions that you will be asked to answer about your emotional state and past history. Please answer the questions to the best of your ability as they apply to your circumstance at the present time. There is no “right” or “wrong” answer to the questions. When you have completed the testing, I will then have the tests scored. This is by mail and takes about 10 days. When I receive the testing back I will contact you by phone to discuss the results either by phone or in person. As your testing is a part of a *Comprehensive Psychological Evaluation*, I will send a summary of the results and/or a copy of the profile to the physician and/or other parties who referred you to my office:

I have read and understand the above. I agree to complete psychological testing and I give permission for Dr. Jacobs to send the results to my physician and other parties as listed above,

Signed:

Name

Date

CONSENT/AUTHORIZATION FORM

Marilyn S. Jacobs, Ph.D., Psy.D.
921 Westwood Blvd., Suite 227
Los Angeles, CA 90024-2942
Telephone: (310) 824-8910

Date: _____

CONSENT FOR TREATMENT: I authorize **Dr. Marilyn Jacobs** to provide psychological evaluation and treatment to me. I have been informed of/understand the reason for this evaluation/treatment. The evaluation/treatment procedure has been (or will be) explained to me in detail and all of my questions will be answered. If the psychological evaluation includes the need for psychological testing, this procedure will be explained to me in detail and the results will be reviewed with me at the completion of the assessment by Dr. Jacobs.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD: I agree that a report will be prepared by Dr. Jacobs to be released to **Dr. Joshua P. Prager and Associates, California Pain Medicine Center**. I also agree that Dr. Jacobs will discuss my evaluation with Dr. Prager for clarification as needed. I also understand that this release includes the staff of the California Pain Medicine Center involved with my care along with Dr. Prager. I further give permission for Dr. Jacobs to discuss my psychological treatment on an ongoing basis in team treatment meetings with Dr. Prager and his staff for the purpose of treatment planning and management.

I also understand that there is an administrative charge for preparation and distribution of any reports which I may request in the future. I understand that I will be given a copy of this release upon request and that this release is revocable if I advise Dr. Jacobs is advised in writing.

This release will take effect on _____ and expire on _____.

Signed: _____

Print Name: _____

Date: _____

Marilyn S. Jacobs, Ph.D.
Licensed Clinical Psychologist
921 Westwood Blvd., Suite 227
Los Angeles, CA 90024-2942
(310) 824 8910

PLEASE READ AND SIGN LAST PAGE

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

[CALIFORNIA]

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your

part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is **\$165.00** for individual psychotherapy sessions. The fee for *Comprehensive Psychological Evaluation* is **\$425.00**. The fee for standardized psychological testing is **\$175.00** per test.

In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge \$450.00 per hour for preparation and attendance at any legal proceeding.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. I do have call-in hours. When I am unavailable, my telephone is answered by a voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical

Record (which is called “PHI” in my Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information).

I also have contracts with Sue’s Secretarial Service. As required by HIPAA, I have a formal business associate contract with this business in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a blank copy of this contract.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative’s) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.

If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have knowledge of a child under 18 or I reasonably suspect that a child under 18 that I have observed has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency, usually the county welfare department. I also may make a report if I know or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well being is endangered in any other way (other than physical or sexual abuse, or neglect). Once such a report is filed, I may be required to provide additional information.
- If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he or she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.
- If I have reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to him or herself, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. There will be a copying fee of 25 cents per page, or 50 cents per page for copies from microfilm (and for certain other expenses). If I refuse your request for access to your records, you have a right of review, (except for information supplied to me confidentially by others) which I will discuss with you upon request.

In addition to the Clinical Record, I also keep a Billing Record, which you may also review according to the terms described above.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information

disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless the psychologist determines that their involvement would be inappropriate. A patient over age 12 may consent to psychological services if he or she is mature enough to participate intelligently in such services, and the minor patient either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse. In addition, patients over age 12 may consent to alcohol and drug treatment in some circumstances. However, unemancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the patient, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement, is also essential, it is usually my policy to request an agreement with minors [over age 12] and their parents about access to information. This agreement provides that during treatment, I will provide parents with only with general information about the progress of the treatment, and the patient's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to

disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. (with the exception of patients covered by worker's compensation insurance or Medicare insurance) It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as

treatment plans or summaries, or copies of your entire Clinical Record. Before I can disclose this information, both you and I must receive a written notification from the insurer stating what they are requesting, why they are requesting it, how long it will be kept and what will be done with the information when they are finished with it. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Rev. 02/07

Signature

Print Name

Date

AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize **Marilyn S. Jacobs, Ph.D.**, to release the following: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to: (Provide name or function and address of person to whom the information is to be released)

I am requesting **Marilyn S. Jacobs, Ph.D.** to release this information for the following reasons, and subject to the following limitations:

This authorization shall remain in effect until (fill in an expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

I understand that I have the right to revoke/modify this authorization, in writing, at any time by sending written notification of that revocation/modification to **Dr. Jacobs'** office address. However, my revocation or modification will not be effective until **Dr. Jacobs** receives it.

I understand that **Dr. Jacobs** generally may not condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in Sections I through III of the Notice form provided by **Dr. Jacobs**, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, **Dr. Jacobs** may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

Signature of Patient

Date

(If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.)

Marilyn S. Jacobs Ph.D. 921 Westwood Blvd., # 227, Los Angeles, CA 90024.

Telephone: 310 824 8910. FAX: 310 552 2151. Email: MJacobsPhD@aol.com

Marilyn S. Jacobs, Ph.D.
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INFORMATION CONCERNING WORKER'S COMPENSATION INSURANCE
COVERAGE FOR MENTAL HEALTH TREATMENT SERVICES

Your physician has referred you to my office for a psychological evaluation in conjunction with your medical treatment. This is a very common type of referral for patients with medical and pain problems.

As your medical care is covered under Worker's Compensation insurance, there are a few issues of which you need to be informed.

In a normal patient-psychologist relationship, there is a strict rule about confidentiality. The patient normally has what is known as the "privilege" and no one else can be told of confidential information disclosed during a psychological evaluation or treatment session without the patient's specific permission. However, when a third party payer such as a Worker's Compensation carrier is paying for the services, these rules are somewhat modified. What this means is that the insurance company and the lawyers for the employer can request and obtain a copy of your psychological record. Furthermore, a summary of what you tell me about yourself will be discussed with the referring physician and the Worker's Compensation insurance company to provide for your care. I will prepare a report with this summary.

During the course of our discussion, if you feel there is a specific issue related to your personal history or current functioning that you do not want communicated to your referring physician or the insurance company, please advise me of this fact.

Please do not hesitate to discuss this issue with me before we begin our interview today. I will be most available to answer all of your questions and explain this further to you.

I have read and understand the above.

Signed:

Date: _____