West Vernon Center
Raleigh Psychological Associates
122 West Vernon Ave
Wake Forest, NC 27587

MINOR PATIENT

HIPAA PRIVACY/PATIENT RIGHTS

A parent of any minor who receives healthcare must sign acknowledgement of the receipt or offer of policies regarding protection of health information (PHI). I affirm that I received or was offered a copy of HIPPA privacy rights entitled, "North Carolina HIPPA Notice Form – Protection of the Privacy of Your Psychological and Other Health Information."

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ACCEPTANCE OF CONTRACT

I accept the terms of this Therapist – Client Psychological Services *Contract* (Version 01/01/13) on behalf of my minor child, and authorize *West Vernon Center, Raleigh Psychological Associates* to provide such indicated, necessary evaluation and treatment as may be ordered and provided by its professional and technical staff, and as I may reasonably request. I agree to abide by all of its terms. If evaluated and / or treated, I will pay all charges arising out of the care of my minor child including but not limited to forensic, copayments, deductibles, charges for missed or late cancelled appointments, and services **not covered** by the insurance company, except those reimbursed directly to Jackelin Veloz-Jefferson, Ed.S., LPA, HSP-P by a third-party* and / or insurer.

**If a third-party will pay the charges, I must provide their written acceptance of responsibility before this contract will be effective, if other than an insurance plan in which Jackelin Veloz-Jefferson, Ed.S., LPA, HSP-P participates.*

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MINOR CHILD

As the parent or guardian of the above-named minor, I affirm that 1) I have the legal authority to independently **authorize** his or her evaluation and / or treatment, 2) I agree that the minor's other parent may be invited to have input or access to the evaluation, treatment, and access to records under the law, unless prohibited by a court order or custody agreement, and 3) I read and accept the **policies and terms** specified in the Child Therapy guidelines.

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INSURANCE

I authorize the release of any medical or other information acquired in the course of the patient's examination and / or treatment to any insurance company, which is necessary to process or substantiate a claim to my minor child's medical insurer or benefits manager for reimbursement of fees for professional services rendered.

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I authorize payment of medical benefits Jackelin Veloz-Jefferson, Ed.S., LPA, HSP-P for professional services rendered to me or to my covered family member specified below during the course of assessment and / or treatment.

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E-MAIL

By signing I authorize Jackelin Veloz-Jefferson, Ed.S., LPA, HSP-P to communicate electronically with me at the email address provided. I accept the risks associated with communication by e-mail, including unauthorized access by third parties, delays in the transmission of information, and computer viruses. If my email address changes, I will notify Jackelin Veloz-Jefferson, Ed.S., LPA, HSP-P as soon as possible. To avoid charges or possible misunderstandings, Email should not be used for complex or sensitive discussions. There are no charges for correspondence regarding administrative matters such as scheduling and billing or for forwarding/receiving documents.

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FAMILY or **PARENTING THERAPY**

I understand that insurance typically does not cover family therapy if the relationship alone is the focus of treatment,; in order to file a medical insurance claim it is necessary that the primary patient have, and be diagnosed with, a valid clinical disorder; there must be medical necessity for treatment using a conjoint modality; medical insurance may not cover even when there is a diagnosis and medical necessity; many insurance policies do not cover session in which the primary, diagnosed patient is not present for most of the session; and Protected Health Information (i.e. medical records) obtained during family sessions will be released only with the consent of the adult patient or minor patient's parent (who has authority to consent). If BCBS, Medicaid or the NC Health Plan does not reimburse Jackelin Veloz-Jefferson, Ed.S., LPA, HSP-P for family or parenting counseling services that I requested or received, I will pay these charges in full at out-of-network rates.

EMERGENCY

I understand that if a medical emergency occurs while I am in the office, either my emergency contact and/or 911 will be called to assist in meeting my medical needs.
Emergency Contact_____
Phone Number of Emergency Contact_____
Relationship to Client_____

On behalf of my minor child (print name: _____) by signing below, I attest that I understand and agree to all and only the provisions specified above that I have initialed.

_____ _____
Signature of parent Signature of other responsible party, if any

_____ _____ _____ _____
Printed name of parent Date Printed name of other responsible party Date

_____
Signature of witness to contract (E.g., doctor)