Nicole Ann Cavenagh, PhD
Marisa C. Hendron, PhD
Licensed Psychologists/Pediatric Neuropsychologists

Welcome to our practice!

Thank you for your interest in neuropsychological assessment at The Center for Child and Family Development. Enclosed you will find the necessary intake paperwork that must be completed and returned to us. Your first appointment will be scheduled once the paperwork is returned to our office. Please complete all enclosed forms and questionnaires to the best of your ability and return them to our office as soon as possible. Additionally, please bring any relevant medical records and/or prior assessment results.

The initial appointment will be a **parent interview only**; your child(ren) **should not** be present. If you choose to bring your child(ren), this appointment **will be rescheduled and may delay the evaluation process for your child**. This appointment will take approximately 30 to 60 minutes and will be used to gather important developmental and historical information about your child.

It may be necessary for your child to attend multiple assessment sessions (1 – 4 sessions). While the assessment of some children may be accomplished in one session, it is not uncommon that a child may require 2 to 4 sessions to complete a comprehensive evaluation. This is because children vary in their ability to pay attention, concentrate, and provide optimal effort.

The 1-hour feedback appointment (scheduled after the completion of all assessments) is very important and gives you the opportunity to meet with your child's doctor to review the assessment results, answer questions, and provide several treatment recommendations for you to consider. At this appointment, you will be provided a comprehensive written evaluation of your child. Your child(ren) **should not** be present for the feedback appointment. If you choose to bring your child(ren), this appointment **will be rescheduled.**

Prior to your child's assessment appointments, please make sure that he/she gets plenty of rest and takes any medications as usual (if applicable). If your child wears glasses, has hearing aids, or has any other assistive devices that are used regularly, please bring them to each assessment appointment. You may also bring a snack for your child if you feel that he/she may need one during the assessment appointment.

We look forward to working with you and your child. If you have any questions, please feel free to contact us at 702.912.5848.

3211 East Warm Springs Rd. Las Vegas, NV 89120 P: (702)912.5848 F: (702) 912.0442

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PACKET CHECKLIST

Welcome to our practice! This is a checklist of the items that we will need before we are able to schedule your first appointment.

- Copy of Insurance Card (Front & Back)
- Copy of Driver's License
- Completed and Signed Registration Form
- Notice of Privacy Practices Signature Page
- Signed Office and Financial Policies
- Legal Guardianship Signature Page
- Signed Patient Rights and Responsibilities
- Child Neuropsychological History Questionnaire
- Copies of prior psychological, neuropsychological, and/or school psychological evaluation reports
- Copies of report cards
- Copy of most recent Multidisciplinary Team Evaluation Report and Individualized Educational Program

We look forward to working with you and your child. If you have any questions, please feel free to contact us at 702.912.5848.

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REGISTRATION FORM

Date	New Patient or Established Patient	SS #

Patient Name:	Last	First	MI

Home Phone	Sex	D.O.B.	Age	Parent Marital Status: (circle one) Married Divorced Widowed Separated Single

Mobile Phone	Other Phone	E-mail

Address	Apt/Space/Unit

City	State	Zip

Parent/Legal Guardian Name:	Parent/Legal Guardian Name:	Patient's School:

Person Responsible for Account's Employer	Occupation

Employer's Address	Work Phone

City	State	Zip

Emergency Contact: Name	Relationship	Phone Number

Primary Insurance: Group #	Member #	Name of Primary Holder
Primary Holder DOB	Relationship to Patient	Insurance Company Phone #

Secondary Insurance: Group #	Member #	Name of Secondary Holder
Secondary Holder DOB	Relationship to Patient	Insurance Company Phone #

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The information on the Registration Form is complete and correct. I hereby assign all medical benefits to which I am entitled to Nicole Ann Cavenagh, PhD/The Center for Child and Family Development in the event that they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to the collection services fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Nicole Ann Cavenagh, PhD/The Center for Child and Family Development as may be dictated by prudent medical practice by my condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

______________________________________ ____________________

Signature of Patient, Parent, or Guardian **Date**

______________________________________ ____________________

Printed Name of Patient, Parent, or Guardian **Relationship to Patient**

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Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY NICOLE ANN CAVENAGH, PhD AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI):

Understanding what it in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, where, and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI), we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act, 45CFR Part 464. The law allow us to use and disclose PHI without your specific authorization for treatment, payment, operations, and other specific purposes explained in this document. This includes contacting you for appointment reminders and follow-up care.

YOUR HEALTH INFORMATION RIGHTS: You have the right to:

- Request a restriction of the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction that you request. You should address your request in writing. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and, upon written request, obtain a copy of your health record for a fee of $.65 per page (a higher fee may be charged for pages both sides of which must be copied or items on nonstandard pages) and the actual cost of postage per NRS 629.061, except that you are not entitled access to, or to obtain a copy of, psychotherapy notes, raw neuropsychological or psychological test data, and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request. In most cases, we will respond within 30 days. We are not required to agree to the requested amendment.
- Obtain an accounting of all disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Request in writing that we communicate with you by a specific method. We will typically communicate with you in person, or by letter, email, fax, and/or telephone.

- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practice with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practice and we will apply the change to all of your protected health information, including information obtained prior to the change.
- Post notice of any changes in our Privacy Policy in the lobby and make a copy available to you upon request.
- Use or disclose your health information only with your authorization except as described in this document.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your health information.

We may use or disclose your protected health information for treatment, payment, and operations, and for purposes described below:

- **Treatment:** We will use and exchange information obtained by a physician, nurse practitioner, nurse, or other healthcare professionals, staff, trainees, and volunteers in our office to determine your best course of care. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treatment medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. we will also provide your health care providers with copies of various reports to assist them in your treatment.
- **Treatment and/or Safety Emergencies:** We may disclose information if a patient is experiencing a treatment emergency and information must be shared with other healthcare providers to ensure safety and protect the patient from immediate harm. Similarly, we may disclose information in the event that a patient becomes unable to care for him or herself and/or threatens to cause serious physical damage/harm to him or herself and/or to another person. Under these circumstances, we will take actions within the limits of the law to prevent the patient from injuring him or herself and/or others and to ensure that the patient receives proper medical care.
- **Payment and/or Default on Payment:** We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment. In the event that you default on payments, we may utilize the services of a collection agency and will release information in accordance with ethical and legal guidelines.
- **Legally Required Disclosures/Legal Issues:** We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. We may disclose PHI to law enforcement such as limited information for identification and location services or information regarding suspected victims of a crime. We may disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena. We may disclose PHI if psychological services were sought in an effort to aid in the commission of a crime or to escape detection or apprehension related to a crime. If a patient files ethical or legal charges against our practice, we may release PHI that may be necessary for our defense.

- **Mandatory Reporting:** Our clinicians are mandatory reporters. As such, if we have reasonable cause to suspect that a minor child, disabled person regardless of age, or an elderly adult has been the victim of, or will be the victim of, physical or sexual abuse, neglect, exploitation, abandonment, or other forms of maltreatment, I am legally mandated to report to the appropriate authorities.
- **Business Associates:** There are some services provided to our organization through contracts with business associates. We may disclose your PHI to these associates so that they can perform these services. We require all business associates to safeguard your information to our standards.

Disclosures Requiring Authorization: All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent that we have already relied upon the authorization.

Nicole Ann Cavenagh, PhD
Marisa C. Hendron, PhD
Licensed Psychologists/Pediatric Neuropsychologists

Acknowledgement of Receipt: Notice of Privacy Practices

Patient Name (Please Print): ____

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). We encourage you to read it in full.

If you have any questions about our Notice of Privacy Practices, please contact our office.

I acknowledge receipt of the Notice of Privacy Practices at The Center for Child and Family Development.

Signature:____
Patient, Parent, or Guardian

Date:____

Print Name:____

Relationship to Patient:____

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OFFICE AND FINANCIAL POLICIES

Thank you for choosing The Center for Child and Family Development as your psychological healthcare provider. Our primary concern is that you receive the optimal and proper services for your child's care. Therefore, if you have questions regarding clinical services, please contact Dr. Cavenagh. If you have any questions about payment or other policies, please contact our front office staff either via telephone or in person.

Appointments and Scheduling:

- All intake paperwork and outside records requested by this office must be provided in advance of the initial parent interview appointment or the appointment will be rescheduled
- Initial interview and feedbacks sessions are to be attended by parents only. Should you choose to bring your child(ren) to these appointments, they will be rescheduled, which may result in a significant delay in your child's evaluation proceedings
- Tardiness:
    - If you are up to 15 minutes late for a scheduled appointment, you will be seen but the appointment will end at the scheduled time
    - If you are 15 minutes or more late, the appointment will be rescheduled
- Cancellations:
    - Please provide 24 hour notice for cancellations. Failure to give 24 hour notice for cancellation for any reason (including traffic, childcare issues, illness, or any other reason) will result in a charge of $50. Please note that your insurance company cannot be charged for a failed or cancelled appointment and you will be responsible for payment
    - Once an evaluation has begun, it must be completed in a timely manner. It is your responsibility to work with our staff to reschedule any cancelled appointments as soon as possible
- Failed/Missed Appointments:
    - If you do not attend a session and do not call to cancel, all of your future appointments will be cancelled

Record Retention:

- Per NRS 629.051, Section 7, psychologists are required to maintain records for adult clients over 23 years of age, for five years. Children's records will be maintained until 23 years of age. After that time, records may be destroyed.

Communication Outside of Scheduled Appointments:

- While our doctors are generally in the office Monday through Thursday between 9 a.m. and 5 p.m., they are rarely immediately available by telephone and does not answer calls while with patients. Please leave a voicemail and every effort will be made to return calls within 2 business days. Please provide times that you will be available in the voicemail
- If you choose to do so, you may contact our office via email. Please note that no clinical services or information may be exchanged via email. Electronic communication, such as e-mail, is not a secure medium for transmission of protected health information and our office cannot guarantee the confidentiality of information transmitted in this way.
- Our clinicians and staff do not accept "friend" or networking requests from patients or patient's family members through social media or other online forums.
- If you are experiencing a medical or psychological emergency, please contact your primary care physician, call 911, or proceed to the nearest emergency room.

Financial Policies:

- Payment for services is due at the time that the service is rendered. This includes fees for uncovered services, unpaid deductibles, co-payments, and any other applicable fees. We accept cash, checks, and credit cards (please contact our front office staff for information on credit cards accepted). If your services are covered by a private insurance company, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. A limited number of insurance companies are billed as a courtesy to our patients but all charges are your responsibility
- By signing below, you authorize release of necessary information to file a claim with your insurance company
- Cash-pay patients can be provided with a "Record of Services Provided and Fees Collected" to submit to their insurance company for possible reimbursement (if the patient is eligible for out-of-network benefits) upon request
- If there is a balance due after your insurance company has been billed/has paid the claim, that balance is due in full within 30 days of receipt
- Failure to pay your account within 90 days will result in your account likely being referred to a collection agency. Expenses incurred by the collection agency will be your responsibility
- Our office **does not** provide refunds for appointments cancelled by patients or that patients failed to attend
- Records requested by another healthcare provider's office can be sent by fax or mail free of charge. Records requested by other entities, including patient/patient's guardian, will be billed separately at $0.65 per page (a higher fee may be charged for pages both sides of which must be copied or items on nonstandard pages) and the actual cost of postage. Payment is expected prior to the release of records.

- At this time, our clinicians are contracted with a limited number of private insurance companies. Charges for services are as follows:
    - Neuropsychological Evaluation for ages 5 years and younger = $1800.00
    - Neuropsychological Evaluation for ages 6 years through 17 years = $2200.00
    - Telephone Consultation Brief (15 minutes or less) = $65.00

- Telephone Consultation Intermediate (15-30 minutes) = $135.00
- Telephone Consultation Complex (up to 45 minutes) = $195.00
- Please inquire with our front office staff should you require information on fees for specific services not listed above

Legal/Custody Evaluations:

- At this time, The Center for Child and Family Development **does not** provide any evaluations pertaining to litigation and/or custody evaluations
- All legal guardians of a child are strongly encouraged to participate in the evaluation proceedings
- All legal guardians must agree to not ask clinicians or staff of The Center for Child and Family Development to testify in court in any way, shape, or form. We will not provide evaluation results to the court for litigation. All legal guardians must agree to instruct their attorneys to not subpoena or refer to clinicians or staff of The Center for Child and Family Development in any way, shape, or form in any court filing. If we are required to testify or release records under court order, we retain the right to terminate psychological services
- Clinicians and staff of The Center for Child and Family Development are ethically bound to not provide opinion regarding either parent's/guardian's fitness for custody or visitation
- If clinicians and/or staff of The Center for Child and Family Development are required to participate in court or legal proceedings of any type, the party responsible for the participation agrees to reimburse The Center for Child and Family Development at a the rate of $1,650.00 for a half-day (up to 4 hours) and $3,000 for a full-day (up to 8 hours) for time spent traveling, preparing reports, testifying, being in attendance, and any and all other case-related activities or costs

My signature, or the signature of parent or guardian, below indicates that I have read, understand, and accept the office and financial policies described within this document.

I hereby give my consent for an evaluation and /or treatment of my child.

Thank you for choosing The Center for Child and Family Development as your health care provider. We appreciate your trust and the opportunity to serve you.

Please sign, date, and return this copy to the doctor's office.

____
Patient Name (Print)

______________________________	______________________________
Parent/ Guardian (Print)	Relationship to Patient
______________________________	______________________________
Parent/ Guardian (Signature)	Date

Parent/ Guardian (Print)	Relationship to Patient
Parent/ Guardian (Signature)	Date
Staff Witness Signature	Date Signed

A copy of this form will be considered as valid as the original. You may request a copy of this form from the front office staff if so desired.

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Legal Guardianship

Patient Name:____

Patient Date of Birth:____

I, the undersigned, indicate by my signature below that I have legal custody/legal guardianship of my child (named above), and, therefore, the right to seek evaluation and/or treatment for my child. I have been advised by The Center for Child and Family Development that it is their recommendation that my child's other parent, if any, be informed of my decision to seek evaluation and/or treatment.

_______________________________ ____________________
Printed Name – Parent or Legal Guardian Date

_______________________________ ____________________
Signature Date

_______________________________ ____________________
Signature of Staff Witness Date

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PATIENT RIGHTS AND RESPONSIBILITIES

You have the **right** to:

- Considerate and respectful care and to be comfortable in the environment where care is delivered
- Receive information about outcomes of your child's evaluation in terms you can understand
- Participate actively in decisions regarding your child's care and to receive as much information as you may need in order to give informed consent
- Be advised if the provider proposes to engage in or perform research affecting your child's care. You have the right to refuse to participate in such research projects and your decisions will **not** affect your right to receive care
- An estimate for the cost of your child's evaluation
- Reasonable responses to any reasonable requests made for service
- Have personal privacy respected. Case discussion, consultation, and evaluation are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. Written authorization shall be obtained before medical records are made available to anyone not directly concerned with your care, except as otherwise required by law. You have the right to access information contained in your records within a reasonable time frame, except in certain circumstances specified by law
- Receive a written "**Notice of Privacy Practices**" that explains how your Protected Health Information (PHI) will be used and disclosed
- Receive care in a safe setting, free from verbal or physical abuse or harassment.
- Receive reasonable continuity of care and know in advance the time of your appointments as well as the identity of the person providing the care
- Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, or marital status or the source of payment for care
- Understand and use these rights and be provided a copy of this document at your request. If for any reason you do not understand or you need help, The Center for Child and Family Development will provide appropriate assistance

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You have the **responsibility** to:

- Follow The Center for Child and Family Development rules and regulations affecting patient care and conduct. This includes the following:
    - Show respect for the rights and privacy of other patients and their families while in the waiting room and other public areas of the office. ALL patients are entitled to a private, quiet atmosphere. This includes monitoring the behavior of other children that you may bring with you to appointments as well as the behavior of your child who is a patient of The Center for Child and Family Development while in the waiting room. Please bring a quiet activity for your child(ren) (e.g., a coloring book, etc.) to use while in the waiting room
    - Accompanying your child(ren) should they need to use the restroom
    - Complete any intake paperwork provided to you prior to your first scheduled appointment or the appointment may be rescheduled
    - Unless actively participating in a session or meeting with your child's clinician, please remain in the waiting room area. Should you require entrance to the clinical areas of the office, please explain your need to front office staff and allow them to assist you
    - **Use of cellular phones (including text messaging) is prohibited in the office. Please turn cellular phones off prior to entering the office**______
    - **Arrive on time for all appointments. If you are up to 15 minutes late, you will be seen but the appointment will end at the scheduled time. If you are more than 15 minutes late, the appointment will be rescheduled** ______
    - **Be respectful of your clinician's time. Please provide 24 hour notice for cancellations. Failure to give 24 hour notice for cancellation for any reason (including traffic, childcare issues, illness, or any other reason) will result in a charge of $50. Please note that your insurance company cannot be charged for a failed or cancelled appointment and you will be responsible for payment** ______
    - **If you do not attend a session and do not call to cancel, all of your future appointments will be cancelled** ______
    - **Once an evaluation has begun, it must be completed in a timely manner. It is your responsibility to work with our staff to reschedule any cancelled or failed appointments as soon as possible** ______
- Be considerate of facilities and equipment and to use them in such a manner so as to not abuse them
- Respect the rights and property of other patients and personnel. Just as you want privacy, a quiet atmosphere, and courteous treatment, so do other patients
- Report, to the best of your knowledge, accurate and complete information regarding any matters pertaining to your child's condition to the clinicians who provide care to your child
- To provide accurate payment information and insurance benefits
- Pay bills promptly to assure that your financial obligation to your child's care are fulfilled. Payment is expected at the time when services are rendered unless other arrangements have been established in advance Fees may be paid by cash, check, or credit card (please see front office staff for credit cards accepted)

Consent:

- Audio and video recording are often a necessary component of a child's evaluation. As such, your child's sessions may be subject to audio and video recording. Your signature, below, indicates that you understand this and consent to having your child's sessions audio and/or video recorded. These recordings will be stored and destroyed in accordance with legal and ethical guidelines.

By signing below I attest that I have read, understood, and agree to comply with the above Patient Rights and Responsibilities.

____

Printed Name of Patient

____

Printed Name of Patient's Representative (if patient is a minor)

____ __________

Signature of Patient (or Patient's Representative if patient is a minor) Date

____ __________

Signature of Staff Witness Date