Debra N. Brosius, Psy.D.

Licensed Clinical Psychologist

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Statement of Practice for Evaluations

Welcome to my practice. This statement provides an overview of my polices and serves to provide information regarding the assessment. It is important to me that you receive quality care and satisfaction. Please read this document carefully. When you sign this document, it will represent an agreement between us. You have the right to revoke this agreement in writing at any time.

Credentials, Education and Experience

I am a clinical psychologist licensed by the Virginia Board of Psychology. I earned my doctoral degree from American School of Professional Psychology in Washington, D.C. I have worked as a psychologist in a variety of international and domestic settings including private practice, a medical hospital, inpatient psychiatric hospitals and Veterans Administration Hospitals. I have also worked in community outpatient clinics with children, adolescents and adults. I have specific training in neuropsychological and psychoeducational assessment. I also provide cognitive remediation for children and adolescents who struggle in school. I am trained in psychotherapy with children, adolescents and adults. I typically employ a supportive cognitive behavioral approach to therapeutic services. I welcome the opportunity to provide you with the highest quality psychological care.

It is important that you understand that psychology, similar to medicine, is not an exact science. Research over the past two decades indicates that as a result of mental health services, most individuals feel and function better in their lives after evaluation or treatment.

Success in psychological settings is dependent on many factors, some of which reside with the client (i.e., motivation for change), and some that reside in the professional (i.e., skills and techniques) and some from the interaction between the client and psychologist. I believe that a strong relationship is paramount to success, regardless of whether the client is seeking an assessment. Examples of a strong therapeutic relationship include but are not limited to: feeling understood and respected, viewing the relationship as a “good fit” and agreeing on the goals and tasks of the professional services.

My practice is also a teaching practice, in that post graduate and graduate students that are supervised by me may be involved in the assessment process. You have the right to decline that the student is involved, if you so choose. **Please initial _______________.**

TERMINATION: As set forth above, after the first meeting, Dr. Brosius will assess if she can be of benefit to you. She does not accept clients who, in her opinion, she cannot help. In such a case, she will provide you with options of professionals whom you can contact. If, at any time, you want another professional's opinion or wish to consult with another therapist, Dr. Brosius will assist you with referrals.

SOCIAL NETWORKING AND INTERNET SEARCHES: I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

Office organization, telephone and emergency coverage

My practice is located at 6845 Elm Street in McLean VA. If services are provided for your child or adolescent, please escort your child to this office. Since assessments take a few hours, depending on the behavior and age of your child we can determine if it is appropriate to leave. For safety reasons, please make sure you are accessible by phone and remain within a 10-15 minute drive. For various reasons, the assessment may be discontinued or we may finish early.

Your telephone calls are very important to me. If I am able, and not working with another client, I will try to personally answer your calls. I also have a personal remote assistant who may take your call and answer questions. Alternatively, I encourage you leave a confidential voicemail. I also welcome you to email me with any questions you may have about my services or practice in general. Please note that email is not considered secure, so please limit the amount of information in your email, as I cannot ensure your privacy in this format. Also, **never email in an emergency situation**.

If you or your child is in crisis and you cannot reach me directly, seek immediate care at your nearest hospital or call 911. The staff that operate emergency services are always available. Please follow up with me once you have stabilized.

Confidentiality and exceptions to confidentiality

Generally, all information related to you or your child is confidential and will be released only with your informed written consent. However, under particular circumstances private information may or is required to be released even without your consent. There are exceptions to confidentiality and please note that I follow the laws of these exceptions from the Virginia Board of Psychology. Under Virginia law, communication between a client and a licensed psychologist is considered privileged (confidential) and may not be disclosed without your consent. The limitations to confidentiality are listed at the end of this document. Please read it carefully.

Fees for Services

Comprehensive assessment services are billed based on the tests administered up to **$3,000 per evaluation.** This fee includes a record review, interview, test time, and a feedback ses-

sion. A formal report will follow in approximately 7-10 business days. The report will not be released until payment is made in full. **Please initial________________**

Insurance is reimbursement is your responsibility. Please be sure to check with your insurance plan to obtain pre-approval so that you can receive the best reimbursement possible. PLEASE NOTE, the report will not be released until payment is made in full. If you need the report sooner and are using insurance benefits, then a retainer for the full fee will be required. I will provide you with documentation of service costs. Please note that most insurance companies DO NOT pay for educational evaluations.

Financial Agreement & Acknowledgement of Privacy Practices

NOTE: YOU MUST SIGN THIS CONTRACT TO BE SEEN BY: Dr. Brosius

Please note I am in-network with Carefirst, Anthem, and Cigna. I do NOT work with Aetna. However, **I cannot guarantee insurance coverage**. The fees are ultimately your responsibility.

I do NOT work with Aetna and have requested removal from the panel. Although in-network with Tricare, they only allow 6 units of psychological testing, and I will not be limited in my approach to answer your referral question. Any units above the limit are your responsibility.

Insurance reimbursement is a contract between you and your insurance company. It is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with me. ***It is your responsibility, as the patient, to understand the limits and restrictions affecting coverage of services you receive.*** The patient is responsible for all co-pay, deductibles, and coinsurance amounts not covered by your insurance policy.
Initial:____________

Charges for all visits, treatments and procedures are due at the time of service. If you have any outstanding balances with me, they must be paid in full before your next date of service.
I accept cash, check, and all major credit cards. For NSF checks, a $50 NSF charge will be billed to your account. If proof of insurance is not provided at the time of service, you are responsible for the entire amount of the visit, treatment and/or procedure at the time of service.
Initial:_____________

For all appointments not cancelled 24 hours before your scheduled appointment, a $100 "No Show Fee" will be billed to your account. Insurance does not cover no show fees.
Initial:_____________

In the event it is necessary to refer your account to collections, you will be responsible for all charges accrued including attorney fees, court costs and all administrative, late and
interest fees.
Initial:_____________

By signing below, you authorize the release of any medical or other information necessary to process claims related to medical services received by yourself or your dependent. You assign all medical payment on your behalf or that of your dependent for services provided to be issued to Dr. Debra Brosius, Psy.D., LLC 6845 Elm Street, Suite 507 in McLean VA 22101.
I am required by law to provide you with a copy of our Notice of Privacy Practices (HIPAA) and my Financial Agreement.
Initial:______________

By signing this form you acknowledge that you have received and read a copy of our Notice of Privacy Practices and dully understand and accept the terms of Dr. Debra Brosius, Psy.D., LLC Notice of Privacy Practices and Financial Agreement.
Initial:_______________

**In the case of an account overpayment, the amount will be applied to your account as a credit unless you request otherwise. Updated January 15, 2017

Thank you for choosing my practice. I look forward to working with you.

AUTHORIZATION, AGREEMENT AND SIGNATURE

Having read, understood and agreed to the above, I authorize Debra N. Brosius, Psy.D. to provide services for ____.

Date:________________________ Signatures____________________________

____

I have read, agree to and understand the HIPAA policy:

Date:_________________________ Signature___________________________________

Debra N. Brosius, Psy.D.

Licensed Clinical Psychologist

Phone: 084 918 2590 email: debrabrosius@gmail.com

Assessment information for Clients/parents of Clients

It is my pleasure to assist you in gathering information. I hope you will find the following information helpful.

Areas of Assessment: The assessment is comprehensive. The results will provide information about intelligence, general cognition, learning style, memory, attention, achievement and social/emotional status (if applicable).

At our first contact, we will discuss your concerns as well as what you want or need from the assessment process. It is very helpful to bring any prior documentation of medical illnesses, school records, achievement, interventions with other specialists (i.e., speech, OT) and previous testing. We are also a teaching practice and have graduate student interns and externs that are supervised by myself and/or the other psychologists in the practice. These students may be conducting the testing. You have the right to decline that the student be involved in the testing process if you so choose.

Assessment outcome: An assessment feedback session will be scheduled to provide you with the findings of the assessment. This may occur via ideally in person. Specific recommendations will be offered and questions will be answered. The total allotted time for the feedback sessions is 45 minutes. If you require more time, the hourly rate will apply. At your written request, I will forward the results to your school, physician, attorney, tutor, or other mental health professional. If a follow-up meeting is required, it will be billed at the hourly rate.

Please initial here _______________ indicating your have read and understand this document.

LIMITATIONS TO CONFIDENTIALITY

Note: All references to “you” or “your” as the client also apply to your minor child

As a general rule, I will not disclose the information obtained from your contacts with me, or the fact that you are my client, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below or as otherwise specified by law. Some of these circumstances are what I determine to be best practice while others are dictated by my professional ethics and/or are required by law.

Under Virginia Law, it is my policy to provide information to others ***without*** your consent in circumstances:

1. **You are in imminent danger of harming yourself or someone else.**
2. There is suspicion of child abuse or neglect.
3. There is suspicion of elder abuse or neglect.
4. There is suspicion of abuse or harm to a disabled individual.
5. There is suspicion of an inappropriate sexual relationship with another health-care provider.
6. If legal action is brought which specifies mental health damages.
7. If there is a court order signed by a judge.
8. **National Security**: Under certain circumstances, disclosure of health information to authorized federal officials may be required for lawful intelligence, counterintelligence, and other national security activities.

ADOLESCENTS: Law allows your parents to obtain information and/or records related to your treatment. Parents: In general, I ask that you transfer your right to privacy to your child; you will, however, be kept informed of the important goals of therapy and how you can be helpful. Any specifics that are important for you to know, I will encourage your child to discuss with you, with my help if necessary.

Information to be provided to a third party payor only with your consent: If you wish to obtain third party reimbursements for mental health services, certain information must be provided. Typically that involves providing information about the dates of treatment, the type of treatment, and your diagnosis. You will process your own insurance claims and this information will be listed on the receipt I provide you for that purpose. If you wish for me to provide more extensive information to your insurance company, you must provide written authorization. It is my policy to provide you an advance copy of the information being submitted to your insurance company.

I understand that if I receive mental health services from Debra N. Brosius, Psy.D., the above limitations may be imposed on confidentiality. I herby accept those limits of confidentiality and consent to receive service under those conditions.

Client signature: _______________________________ Date: _________________

By signing below, I understand that if I cancel the test session without giving Dr. Brosius 24 hours of notice, then I am responsible for a $100 fee that is NOT covered by insurance:

Client Signature: _______________________________ Date: _________________