MICHELLE MOLINA, PH.D.
(949) 253-4144 PHONE
(949) 253-4142 FAX

2102 BUSINESS CENTER DRIVE
SUITE 130
IRVINE, CA. 92612

Informed Consent and Notice of Privacy Practices

Psychological Services:

Thank you for allowing us to participate in your or your child's evaluation. During this process, the patient will be involved in an evaluation of neuropsychological, cognitive, academic, personality, developmental, and social/emotional functioning. These results will be utilized in conjunction information from parent(s), teacher(s), and other involved parties (therapist, psychiatrist, social worker) in order to develop a diagnosis and treatment plan. Testing results, diagnosis and treatment recommendations will be contained in a formalized, written report provided to the patient or parent/legal guardian.

Professional Records:

The laws and standards of this profession require that we keep evaluation and treatment records. You are also entitled to receive a copy of testing records, unless it is determined that to do so would be emotionally damaging. In this case, a testing summary will be provided.

Minors:

For patients under the age of eighteen years old, evaluation results will be provided to a parent or legal guardian unless to do so would be professionally contraindicated.

Billing and Payments:

Patients are responsible for payment for services. When health insurance coverage is provided, the patient or parent/legal guardian will receive advance notice of services covered and any out of pocket charges required for a comprehensive evaluation. If a patient is paying for services without health insurance coverage they will be responsible for payment upon service.

Privacy Practices:

This information describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other

purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” (PHI) is information about the patient, including demographic information and information which is related to past, present or future physical or mental health conditions related to mental health care services.

We are obligated to abide by the terms of the privacy practices.

Your signature indicates that you agree to allow us to use and disclose PHI for the purpose of providing mental health evaluation services. PHI may also be used and disclosed to pay mental health care bill and to support the operations of this office.

Examples of Uses and Disclosures of PHI:

Treatment: PHI will be used and disclosed to coordinate or manage treatment. For example, we will disclose PHI to other mental health professionals who are involved in treatment when we have the necessary permission to do so.

Payment: PHI will be used, as needed, to obtain payment for health care services. For example, your/your child’s health insurance plan may require information in order to make a determination of eligibility or coverage for insurance benefits, reviewing services provided to you, and utilization review activities.

Healthcare Operations:

We may use or disclose, as needed, your PHI in order to support the business activities of this office. The activities may include, but are not limited to quality assurance activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use your/your childs’ PHI for appointment reminders. We will also share your/your child’s PHI for purposes of billing or transcription services.

Uses and Disclosures of Protected Health Information With Your Written Authorization:

Other uses and disclosures of your/your child’s PHI will be made only with your written authorization, unless otherwise permitted or required by law. For example, in order to coordinate care, you may wish to allow Dr. Molina to contact your child’s teacher or therapist in order to provide continuity of care.

Other Permitted and Required Uses and Disclosures of PHI Which May be Made With Your Consent, Authorization, or Opportunity to Object:

Facility Directories: Unless you object, we will use and disclose in our facility directory your name and location where you are receiving care.

Others Involved In Your Healthcare: Unless you object we may disclose to a member of your family, a relative, a close friend or any other person you identify who directly relates to your healthcare. This may involve disclosure of your PHI to a foster parent, or social worker.

Emergencies: We may use of disclose your PHI in an emergency treatment situation. If this occurs, Dr. Molina will obtain your consent as soon as reasonably practical after delivery of treatment.

Communication Barriers: We may use and disclose your PHI if Dr. Molina requires translation of your evaluation services.

Other Permitted/Required Uses and Disclosures Which May Be Made Without Your Authorization or Opportunity to Object:

We May Use Your Protected Health Information (PHI) Without Your Authorization:

1. *Child Abuse:* If Dr. Molina has cause to believe that a child has been or may be abused or neglected, she must take action to protect that child or other children who may be harmed.
2. *Adult and Domestic Abuse*: If Dr. Molina has cause to believe that an elderly or disabled person is being abused, neglected, or exploited, she must report such to the appropriate authorities.
3. *Serious Threat to Health or Safety*: If a patient is threatening serious bodily harm to self or others, Dr. Molina will disclose relevant PHI to medical or law enforcement professionals.
4. *Judicial or Administrative Proceedings*: In some legal in which the patient's emotional functioning is an important issue, a judge may order Dr. Molina's testimony.

Rights' During Evaluation and Treatment:

Right to Inspect and Copy: You have a right to inspect and have a copy of your/your child's PHI. If Dr. Molina has determined by professional judgment that your best interest requires restriction of such information, you will be provided with a summary of your/your child's PHI.

Right to Receive Confidential Communication with Alternate Means or Location. For example, you may not want a family member to know about your/your child's treatment and may request that communication be sent to an alternate address.

Right to Amend. You have the right to request an amendment of PHI.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of PHI.

Right to Paper Copy. You have a right to receive a paper copy of this notice.

Complaints: If you are concerned that your rights were violated, you may contact the Privacy Contact at (949) 253-4144 or Jessica Johnson at (818) 343-0322 (for Medi-Cal patient's).

Informed Consent to Treatment:

I understand that psychological evaluation services may include direct face to face contact, interviewing, testing, and consultation. I agree to supply full answers, make an honest effort, and work as best I can to make sure that the findings are accurate. I also consent to take part in, or have my child take part in psychological testing and evaluation.

I understand these services are being provided for the purposes of diagnosis and treatment planning.

Acknowledgement of receipt of privacy practices:

I acknowledge receipt of the Informed Consent and Privacy Practices which explains limits on ways in which Molina Psychological Consultants may use or disclose personal health information to provide services.

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Patients Name:____

Patient Signature:____

Signature of Parent:____

Signature of Patients' Legal Guardian/Representative:_________________________

Date: __________________

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Date:_____________________