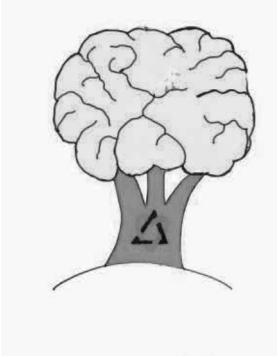


New Beginnings Neuropsychology, PLLC
Crystal Beadle, Ph.D.
4645 Avon Ln, #160A
Frisco, TX 75033
Tel: 469-731-5440
Fax: 469-731-5537

CONSENT FOR EVALUATION

Referral Source: Your child has been referred for a neuropsychological assessment (i.e., evaluation of his or her thinking abilities) by _____.

Nature and Purpose of Assessment: The goal of neuropsychological assessment is to determine if any changes have occurred in your child's attention, memory, language, problem solving, or other cognitive functions. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your child's background and current medical symptoms, we may be using different techniques and standardized tests including but not limited to asking questions about your child's knowledge of certain topics, reading, drawing figures and shapes, listening to recordings, viewing printed material, and manipulating objects. Other specific goals and anticipated uses of the information we gather today includes the following: _____

Foreseeable Risks, Discomforts, and Benefits: For some individuals, assessments can cause fatigue, frustration, and anxiousness. Other anticipated risks, discomforts, and benefits associated with this assessment includes the following:_____

Fees and Time Commitment: The fee for this assessment is: _____. Assessments may take several hours or more of face-to-face testing and several additional hours for scoring, interpretation, and report preparation. This evaluation is estimated to take approximately _____ hours of face-to-face assessment time. The fees collected will cover the interview, assessment, and parent feedback session.

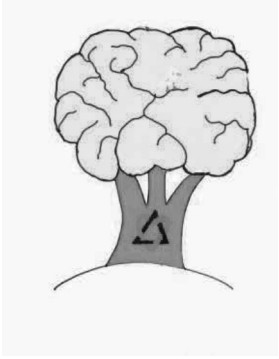
Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law. Other foreseeable limits to confidentiality for this assessment include:_____

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

_____ _____
Parent/Guardian or Authorized Surrogate (if applicable) Date

_____ _____
Patients Name Date of Birth

_____ _____
Witness Signature Date



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TEXAS NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- ***"PHI"*** refers to information in your health record that could identify you.
- ***"Treatment, Payment and Health Care Operations"***
- ***Treatment*** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- ***Payment*** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- ***Health Care Operations*** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- **"*Use*"** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"*Disclosure*"** applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. ***"Psychotherapy notes"*** are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization:

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the Texas State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

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IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- ***Right to Request Restrictions*** –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances (specifically, access to raw neuropsychological test protocols), but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- New Beginnings Neuropsychology, PLLC is required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will make every effort to notify you of changes that could affect our handling of your PHI.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Crystal Beadle, Ph.D. at 469-731-5440.

If you believe that your privacy rights have been violated and wish to file a complaint with our clinic, you may send your written complaint by mail or e-mail to Dr. Beadle at the address above or to newbeginingsneuro@gmail.com.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

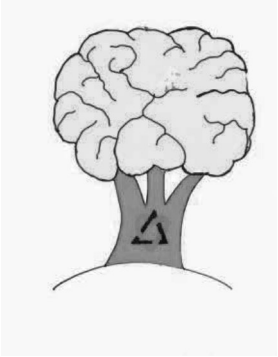
VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on July 1, 2016.

Dr. Beadle will limit the uses or disclosures that I will make as follows:

- Release of raw neuropsychological test protocols (raw data) to anyone other than a qualified mental health professional, except in the case of a court order requiring us to release this data. Raw data refers to the actual test materials and recording forms on which the test copyrighted test items are printed. This material is considered to be the property of the psychologist, not the patient, since open access to the tests themselves can damage the validity of the test due its content being exposed to the public. Exposing the test content to the public makes them potentially useless, as would exposing the items to the SAT, ACT or TAKS tests in educational settings. This practice is mandated by the Texas State Board of Examiners of Psychologists.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or e-mail.



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RECEIPT OF PRIVACY PRACTICES

I have read the above policy and understand its contents regarding the protection of my records, disclosure of them, and my access to them. I agree with the terms of this policy as stated.

_____ _____
Patient or Representative Date

_____
Relationship of Representative

_____ _____
Patient Name Date of Birth

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Communication by Email, Text Message, and Other Non-Secure Means

Options for communication include email, text message (e.g. "SMS"), and electronic voice mail. Be informed that these methods may not always be confidential means of communication. If you choose to use these methods to communicate with New Beginnings Neuropsychology, PLLC, there is no guarantee of complete confidentiality. The kinds of parties that may intercept these messages may include, but are not limited to:

- Others in your home or other workplace who have access to your phone, computer, or other devices that are used to read and write messages.
- Your employer, if you use utilize work email to communicate with New Beginnings Neuropsychology, PLLC.
- Unknown persons in the event of loss or theft of devices.

I consent to allow New Beginnings Neuropsychology, PLLC to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of appointments
- Information related to billing and payment
- Completed forms, including forms that may contain sensitive, confidential information
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health record, in part or in whole, or summaries of material from my health record, including psychological or neuropsychological evaluation reports.
- Other information as follows: _____

BY THE FOLLOWING NON-SECURE MEDIA: Check all that apply:

□ Voice mail.
□ Okay to leave detailed messages
□ Unsecured email.
□ SMS text message (i.e. traditional text messaging) or other type of "text message."

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

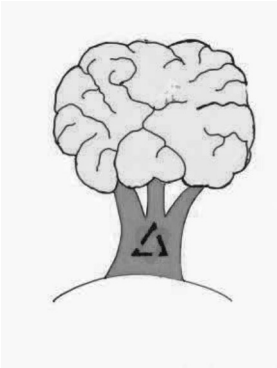
_____ _____
Signature (parent or guardian if patient is a minor) Date

_____ _____
Printed name Printed email address

_____
Phone number

I decline all electronic communication (email, text messaging, voicemail). I understand I will receive phone calls and US Postal mail only. I will not receive reminder notices for appointments or electronic copies of any evaluation reports without express written consent.

_____ _____
Signature (parent or guardian if patient is a minor) Date



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Payment Policy

New Beginnings Neuropsychology, PLLC is honored to serve you and your family. It is our hope to provide your family the best possible care. It is our policy to make financial arrangements **before** any testing or treatment is started. Please review the payment policy described below, and do not hesitate to ask any questions.

1. Payment for services is due at the time services are rendered. We accept cashiers checks, money orders, cash, debit, and credit cards.
2. If you have insurance coverage you wish to use, we will help you with your insurance company by providing such services as verifying benefits and obtaining an estimate of coverage, filing claims, and providing whatever reasonable information your insurance company requests from us. However, please be advised that working with your insurance company is a courtesy service provided by New Beginnings Neuropsychology, PLLC, and we cannot guarantee that your insurance company will cover services or pay claims filed. **If your insurance company does not pay for any reason, you will be responsible for your remaining balance.**
3. We offer 90 day (3 month) no-interest payment plans upon request. The total will be billed in three equal monthly installments on the 1st of the month. If the account remains unpaid after 90 days this office will be required to employ a collection service to collect payment. The responsible party agrees to pay reasonable and related fee collection fees.
4. The parent or guardian who bring the child for their initial visit is responsible for payment independent of what a divorce decree states. Reimbursement must be made between the divorced parents and we will not intervene.
5. Your appointment is reserved just for you. We require 24-hour notice of cancellation. **If cancelling within the 24-hour period of your appointment or if the appointment is missed without notification, you will be charged a $75 cancellation/no-show fee.** Cancellations for Monday appointment must be made by Friday at 5:00 pm.
6. We require payment for the following additional services:
    - Telephone consultations are billed in 15 minute increments at our usual clinical rates.
    - Completion of disability forms, insurance reports, letter, and other forms of written communication are billed in 15 minute increments at our usual clinical rates.
    - Educational and legal consultation, report writing, correspondence, and telephone contact for legal action are billed at $200 per hour for all clinicians. Payment in full is requested prior to releasing the prepared letters and reports in legal matters.
7. You may request one copy of your medical record for yourself in accordance with Health Insurance Portability and Accountability Act (HIPAA) at no charge. All subsequent record reproduction(s) will cost $10 per copy.

I have read and accept the above Payment Policy. I understand and agree to the terms set forth regarding payment.

_____ _____

Individual Receiving Services (Patient) Date of Birth

_____ _____

Signature of Parent or Responsible Party Date