

DAVENPORT PSYCHOLOGY

LICENSED PSYCHOLOGIST PY7978
PHONE: (941) 321-1971 • FAX: (941) 866-0936
CRD@DRCHARLESDAVENPORT.COM

1608 OAK ST
SARASOTA, FLORIDA 34236
WWW.DRCHARLESDAVENPORT.COM

Child Information Form

A. Identifications

1. Child's name: _____ Birthdate: _____ Age: _____

Person(s) completing this form: _____ Today's date: _____

2. Mother's name: _____ Birthdate: _____ Home phone: _____

Address: _____

Email: _____ Education: _____

Occupation: _____ Currently employed: No Yes,

Where: _____ Work phone: _____

Is this the child's: natural mother step mother adoptive mother foster mother guardian

Does this mother live with the child: No Yes

3. Father's name: _____ Birthdate: _____ Home phone: _____

Address: _____

Email: _____ Education: _____

Occupation: _____ Currently employed: No Yes,

Where: _____ Work phone: _____

Is this the child's: natural father stepfather adoptive father foster father guardian

Does this father live with the child: No Yes

4. Parents are currently Married Divorced Remarried Never married Other: _____

Child's custodian/guardian is: _____

5. Stepparent's name: _____ Birthdate: _____ Home phone: _____

Address: _____

Currently employed: No Yes, as: _____ Work phone: _____

6. Siblings:

Name	Age	Grade or Occupation	Relationship with Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7: Others who live in the home with the child:

Name	Age	Grade or Occupation	Relationship to Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Schools

1. School (name, district, address, phone) Grade Age Teacher

2. May I call and discuss your child with the current teacher? Yes No

3. Has this child passed each grade?: Yes No If not, please provide more information: _____

4. Is this child in special classes in school?: Yes No If yes, list special classes: _____

5. Has this child ever been suspended expelled or received discipline or detention for behavior problems? Please provide more information: _____

D. Medical Care: From whom or where does this child get medical care?

1. Clinic/doctor's name: _____ Phone: _____

Address: _____

Any other medical or mental health professions who have seen or currently see this child (Name, address, phone number): _____

2. If this child enters treatment with me for psychological problems, may I tell their medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

3. Does this child have any medical problems, hospitalizations, or serious illnesses?: Yes No; If yes please list:

4. Does this child have vision problems? Yes No

5. Hearing Problems? Yes No

6. Does this child have any allergies to medications?: Yes No; If yes please list: _____

7. Is this child currently prescribed any medications?: No Yes. If yes what medication(s), what dose and who prescribes them?: _____

C. Special skills or talents of child

1. List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: _____

Date

Parent's or Guardian's Signature

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Child Developmental History Record

A. Identifications

1. Child's name: _____ Birthdate: _____ Age: _____

Person(s) completing this form: _____ Today's date: _____

B. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery

Prenatal medical illnesses and health care: _____

Was the child premature? No Yes. Weight and height at birth: _____ pounds _____ inches

Any birth complications or problems? _____

2. The first few months of life

Breast-fed? If so, for how long? Any allergies? _____

Sleep patterns or problems: _____

Personality: _____

3. Milestones: At what age did this child do each of these?

Smiled: _____ Sat without support: _____ Crawled: _____ Stayed dry all night: _____

Walked without holding on: _____ Spoke First Words (besides ma-ma or da-da): _____

Helped when being dressed: _____ Tied shoelaces: _____ Buttoned buttons: _____

Ate with a fork: _____ Stayed dry all day: _____ Didn't soil his or her pants: _____

4. Speech/language development

Age when child said first word understandable to a stranger: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

5. Coordination (circle one)

Walking	Good	Average	Poor
Running	Good	Average	Poor
Catching	Good	Average	Poor
Throwing	Good	Average	Poor
Buttoning	Good	Average	Poor
Writing	Good	Average	Poor

Other concerns with coordination: _____

C. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

D. Residences

1. Homes

Dates		Location	With whom	Reason for moving	Any problems?
From	To				
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

2. Residential placements, institutional placements, or foster care

Dates		Program or location	Reason for placement	Problems?
From	To			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

E. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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Child Checklist of Characteristics

Child's name: _____ Birthdate: _____ Age: _____

Person(s) completing this form: _____ Today's date: _____

Many concerns can apply to both children and adults. Review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- | | |
|---|--|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Cheats |
| <input type="checkbox"/> Argues, "talks back," smart-alecky, defiant | <input type="checkbox"/> Cruel to animals |
| <input type="checkbox"/> Concern for others | <input type="checkbox"/> Complains |
| <input type="checkbox"/> Cries easily, feelings are easily hurt | <input type="checkbox"/> Dawdles, procrastinates, wastes time |
| <input type="checkbox"/> Difficulties with parent's paramour/new marriage/new family | <input type="checkbox"/> Dependent, immature |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Disrupts family activities |
| <input type="checkbox"/> Disobedient, uncooperative, refuses, doesn't follow rules | <input type="checkbox"/> Dropping out of school |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Exercise problems |
| <input type="checkbox"/> Extracurricular activities interfere with academics | <input type="checkbox"/> Failure in school |
| <input type="checkbox"/> Fighting, hitting, aggressive, hostile, threatens, destructive | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Friendly, outgoing, social |
| <input type="checkbox"/> Hypochondriac, always complains of feeling sick | <input type="checkbox"/> Independent |
| <input type="checkbox"/> Immature, "clowns around," has only younger playmates | <input type="checkbox"/> Imaginary playmates, fantasy |
| <input type="checkbox"/> Interrupts, talks out, yells | <input type="checkbox"/> Lacks organization, unprepared |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Likes to be alone, withdraws, isolates |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Low frustration tolerance, irritability |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Mute, refuses to speak | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Obedient | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Insulting, name calling, intolerant | <input type="checkbox"/> Pouts |
| <input type="checkbox"/> Recent move, new school, loss of friends | <input type="checkbox"/> Responsible |
| <input type="checkbox"/> Rocking or other repetitive movements | <input type="checkbox"/> Runs away |
| <input type="checkbox"/> Sad, unhappy | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Shy, timid | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Suicide talk or attempt | <input type="checkbox"/> Swearing |
| <input type="checkbox"/> Temper tantrums, rages | <input type="checkbox"/> Thumb sucking, finger sucking, hair chewing |
| <input type="checkbox"/> Tics—involuntary rapid movements, noises, or word productions | <input type="checkbox"/> Teased, picked on, victimized, bullied |
| <input type="checkbox"/> Truant, school avoiding | <input type="checkbox"/> Underactive, slow-moving, or lethargic |
| <input type="checkbox"/> Uncoordinated, accident-prone | <input type="checkbox"/> Wetting or soiling the bed or clothes |

- Work problems, overworking, can't complete tasks
- Conflicts with parents over rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Self-harming behaviors—biting or hitting self, head banging, scratching self
- Need for high degree of supervision at home over play/chores/schedule
- Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Lacks respect for authority, insults, dares, provokes, manipulates
- Oppositional, resists, refuses, does not comply, negativism
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Distractible, inattentive, poor concentration, daydreams, slow to respond

Any other characteristics:

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PSYCHOLOGIST-PATIENT SERVICES AGREEMENT & INFORMED CONSENT

Welcome to our practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which I provide to you at the end of our first session, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in simple statements. It varies depending on the personal characteristics of the psychologist and patient, and the particular problems the patient is experiencing. There are several different methods that I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things that we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your psychological and behavioral needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information and your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

During our meetings, your therapy will progress more effectively if you talk as freely as you can about any of the problems that may be affecting you at the time of our session. If there are no difficulties that you are aware of at that particular moment, try to talk as freely as you can about everything that is on your mind. This includes thoughts, feelings, memories, perceptions, dreams, and questions. The more open and honest you can be and communicate fully whatever is on your mind, the better. When a person speaks freely about whatever it is that comes to his/her mind, the important issues that relate to their difficulties tend to emerge naturally. Therefore, regardless of whether what comes to your mind seems trivial or important, it will help the progress of your treatment if you go ahead and talk about it in the session.

My task will be to try to assist you to gain understanding of what is unknown to you. The way that I do this is by listening closely to your efforts to explain to me everything that you do know and are aware of about yourself. At times, your thoughts about yourself may be expressed in the form of questions. I may or may not answer your questions according to what I think will be most helpful. This may feel awkward and

uncomfortable to you at first and it is one of the unique things you will find about therapy that makes it different from other relationships that you have.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one session per week at a time we agree on (sessions are 45 to 55 minutes for individuals and 50-55 minutes for couples and families), although I may recommend to have sessions more or less frequently. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide a minimum of 24 business hours during which my office is open (M., T., W., Thu., Fri.) advance notice of cancellation [unless we both agree that you were unable to attend or to cancel the appointment due to circumstances beyond your control].

It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to fill your appointment hour and when I can, you will not be charged even if you have not given 24 hours advance notification. Therefore, if you do not provide any notification when you otherwise could have to allow me the opportunity to fill your appointment hour for that day, you will be personally responsible for the charges. If you have any questions about this policy, please be sure to discuss this with me at your next appointment.

PROFESSIONAL FEES

The hourly rate for Dr. Davenport, Licensed Psychologist is \$300, \$200 for Dr. Gohil, Provisional Psychologist Licensee, and \$200 for Alejandro Sanchez, Psy.D., Psychology Resident and this is the fee that we charge for the first appointment which is 45 - 60 minutes and covers the additional time and costs involved in gathering much of your history and background information which may involve securing copies of records, having contact with previous providers, contacting your insurance provider and to create a new patient file. The per session fee is \$300 for Dr. Davenport, \$200 for Dr. Gohil, and \$200 for Dr. Sanchez, for a 45 - 55 minute session, 45 to 55 minutes for individuals and 50 to 55 minutes for couples/families. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, psychological testing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Dr. Gohil and Dr. Sanchez, are an independent contractors for Charles R. Davenport, Psy.D., LLC.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Please discuss this with me as early as possible if you believe you will want me to be involved in this type of work on your behalf. Out-of-office time for legal matters is computed on a portal-to-portal basis. My fee for any legal or forensic work is \$550 (Same rate for all providers) per hour billed in one hour increments.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 7 PM, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail, which I monitor frequently between the hours of 9:00 AM and 7:00 PM. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. You may also contact:

Bayside Center for Behavioral Health (800) 764-8477
Coastal Behavioral Healthcare, Inc. (941) 552-1950

SERVICES AGREEMENT & INFORMED CONSENT

I may also be contacted by email, and by fax. My email and fax accounts are private and confidential and only I have access to them. Please be aware, however, that it is possible for these types of communications to be misrouted or otherwise intercepted so please take this into account if you utilize these forms of contact or provide an email address to the office. If you choose to use email for communication or provide an email address on intake forms or by sending an email to the office, it will be assumed that you understand and consent to use of email communication. If at anytime you have questions, would like to revoke use of email, or change your email address of record, please contact the office to do so.

I usually take vacations twice a year for 2-3 weeks at a time in July, and again in December. I will always discuss upcoming breaks in advance so that we can prepare for the interruption in the treatment or other services. I will offer to provide you with the name of a colleague to contact during these breaks, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on the accompanying Acknowledgement Receipt provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- I also may have contracts with accounting services, collection agencies and legal services. As required by HIPAA, if contracted I will have a formal business associate contract with these business(es), in which they are duty bound to maintain the confidentiality of this data, except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is potentially protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me in writing that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment.

- If I know or have reason to suspect that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that there is domestic violence occurring in a home where a minor is residing, the law requires that I file a report with the Florida Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires that I file a report with the Florida Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the patient.
- If you inform me that another licensed health care professional in the State of Florida has engaged in any form of sexual behavior with a patient, I must report this to the appropriate licensing board in the state.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is seemingly reasonable and appropriate. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that the practice keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, except for "psychotherapy notes" at my discretion, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, the practice is allowed to charge a copying fee (and for certain other expenses). The practice may withhold copies of your records until payment of the copying fees has been made. The exceptions to this policy are contained in the attached Notice Form. If the practice refuses your request for access to your records, you have a right of review, which the practice will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and potentially control access to the records of) diagnosis and treatment in a crisis situation. When a crisis situation is not present, then parental consent must be obtained for any person under the age of 18 from their parent or legal guardian prior to the start of treatment. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions upon their request. I will also provide parents with a summary of their child's treatment when it is complete upon their request. Any other communication will require the child's written Authorization, unless I believe that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, the practice may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information that I release in regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. A service charge of 3% per month will be added to all accounts over 60 days late. If legal or collections action is necessary, all of its costs will also be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I am not an in-network provider for any insurance and do not file claims, submit diagnoses, or complete related forms for you. If you choose to use your health insurance for "out-of-network" reimbursement, you (not your insurance company) are responsible for full payment of my fees and filing all paperwork as required by your policy. It is very important that you find out exactly what mental health services your insurance policy covers and what forms need to be filed when for out-of-network coverage.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients believe that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company may require that you provide it with information relevant to the services that I provide to you. They may need a clinical diagnosis. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

If you are eligible for Medicare or a Medicare replacement/advantage plan you must complete the attached "Private Contact for Services." This form must be completed due to me being an "opt-out" provider with Medicare. You will be responsible for paying for sessions at the time of service and are restricted from filing for reimbursement from Medicare or any related replacement/advantage plans. Please see the attached contract for more information in this area and discuss any questions with me.

SUPERVISORY RELATIONSHIP

Swapnil Gohil, Psy.D., PPY326 is a Provisional Psychologist Licensee working under the direct supervision of Charles R. Davenport, Psy.D.. Dr. Davenport will supervise all of Dr. Gohil's clinical work and delivery of professional services. Any concerns or complaints regarding Dr. Gohil or his provision of psychological services should be directed to: Charles R. Davenport, Psy.D.: crd@davenportpsychology.com or 941-702-2457.

Alejandro Sanchez, Psy.D. is a Psychology Resident working under the direct supervision of Charles R. Davenport, Psy.D.. Dr. Davenport will supervise all of Dr. Sanchez's clinical work and delivery of professional services. Any concerns or complaints regarding Dr. Sanchez or his provision of psychological services should be directed to: Charles R. Davenport, Psy.D.: crd@davenportpsychology.com or 941-702-2457.

INFORMED CONSENT

- I do hereby seek and voluntarily consent to take part in treatment with Davenport Psychology, its employees, and independent contractors. I understand that in this treatment, we will be working on goals to lessen the problems and concerns that we identify and discuss. As time goes on, we will review our goals and additional goals may be defined. I understand that the development and regular review of these goals are in my best interest and I agree to play an active role in this process.
- I am aware that during the course of treatment, there is a risk that I may have uncomfortable or upsetting feelings. I also understand that my problems and symptoms may temporarily worsen at times during my treatment and my relationships with others may be disrupted as a result of my attempt to make important changes in my life. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Davenport Psychology or its independent contractors.
- I am aware that I may stop my treatment at any time. Should I do so, I will only be responsible for the payment of services I have already received.

Your signature on the accompanying Acknowledgement Receipt indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Davenport Psychology
Notice of Privacy For Protected Health Information
(Notice Form)

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 written 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 written 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 clinical 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.

I will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice.

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 know or have reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Domestic Violence with Minors Present:** If I know or have reasonable cause to suspect that there is domestic violence between adult partners occurring in a home where minors are residing, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Licensed Professional Sexual Misconduct:** If I know or have reasonable cause to suspect that another licensed health care professional in the State of Florida has engaged in any form of sexual behavior with a patient, I must report this to the appropriate licensing board.
- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has 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 or 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 legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being (*continued*)

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:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

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 in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request 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 regarding you. 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.
- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI.** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted
- to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been
- compromised.

Psychologist's Duties:

- I am 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 notify you of any such changes either verbally or in writing.

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 Dr. Davenport at (941) 321-1971.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to:

Davenport Psychology
1608 Oak St, Sarasota, FL 34236
crd@drcharlesdavenport.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 December 21, 2020.

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 either discussing this with you verbally and/or informing you in writing.

