

Information Sheet

Name: _____

Date of Birth: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone (home): _____ **Phone (cell):** _____

Phone (work): _____ **e-mail:** _____

Emergency Contact: Name: _____ **Phone:** _____

Type of Insurance: _____ **Policy #:** _____

Guarantor of Policy:

Self

Other **Name:** _____ **Relationship:** _____

Address: (if different) _____

DOB: _____ **Gender:** M F

Primary Care Physician: _____ **Phone:** _____

Address: _____

Psychiatrist (if applicable): _____ **Phone:** _____

Address: _____

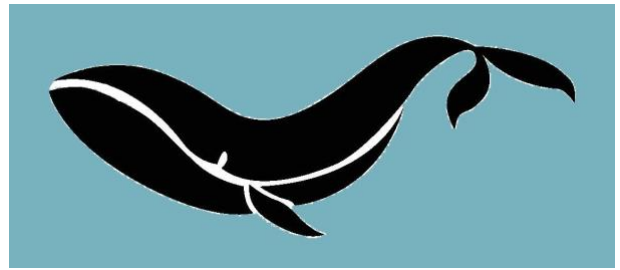
Other Therapist (if applicable): 1. _____ **Phone:** _____

2. _____ **Phone:** _____

Current Medications (list all & dosage): _____

John T. Langfitt, Ph.D., ABPP-Cn

Board Certified in Clinical Neuropsychology
American Board of Professional Psychology
NY State Psychology License 101929
Vermont Psychology License 048.0134720



CONSENT FOR CLINICAL EVALUATION AND TREATMENT

Welcome to my practice. I appreciate that you have chosen me to provide neuropsychological services to you. I will endeavor to make your evaluation or therapy with me successful and productive. This document contains information about both neuropsychological evaluation and psychotherapy as well as financial and business policies that I am required to have you review before we begin. Please read it carefully and ask for any clarification. When you sign this document, it will represent an agreement between us. It will reflect your consent to an evaluation and to allow appropriate treatment (if indicated) to be provided by me. You may withdraw your consent at any time by telephone, in person, or in writing. If you decide to discontinue therapy, I ask that you agree to provide sufficient notice to allow for a therapeutic end to our work together.

Therapy: The process of therapy is intended to help you identify internal psychological problems and make changes in your thoughts, feelings and behavior to help solve them. We will discuss your goals for treatment and actively work toward achieving those goals. This inevitably involves discussing unpleasant aspects of your life and may involve periodic and temporary worsening of symptoms. Change may be difficult and uncomfortable at times. While I will work hard to guide you during this process, therapy requires your active effort both during and between sessions. It is not something I "do" to you, but a process that you embark on with me working with you, side by side. Therefore, I cannot guarantee any particular outcome.

Neuropsychological Evaluation: A neuropsychological evaluation typically involves a focused clinical interview and, usually, some amount of formal cognitive tests. It is conducted to describe strengths and weaknesses in a person's thinking ability, mood and behavior. It helps determine how these strengths and weaknesses may be related to a neurological or psychological problem that the person may have, such as a stroke, brain injury or illness, or other medical or psychological condition. The evaluation helps to determine what kinds of daily tasks may be challenging for the person, what tasks they may need help with and the kinds of treatments or help that they may need to feel more comfortable and function more effectively in their daily lives.

Answering some of the interview questions may make you uncomfortable, but I promise to treat you with respect and make you as comfortable as I can. Some tests are quite challenging, so you may get frustrated at times. Everyone who takes these tests has difficulty at some point. All you can do is do your best. You may also be asked to complete questionnaires about your mood, behavior, attitudes, and beliefs. It is very important that you try your hardest and give your own opinion of yourself and tell the truth. While benefits can be expected, I cannot guarantee that I will be able to give a definitive answer to the questions posed in the evaluation.

FEES and POLICIES

Therapy- **\$150 for a 50-minute therapy session.** This fee is based on the current market rate for professionals with my level of training. To broaden access to my services for those who wish to pay through their health insurance, I bill the insurance company directly for their standard fee, which is generally lower. The client is responsible for all insurance co-payments, co-insurance and deductibles. These are billed to the client quarterly.

Clinical Neuropsychological Evaluation - \$900 for evaluation and feedback session. The full fee is payable via cash, check, credit card or Venmo at the time of the feedback session. If you wish to have insurance reimburse you for the cost of the evaluation, please let me know when we set up the appointment. Some insurances require documentation of the medical necessity of the evaluation in order to provide prior authorization, which can take a week or so. I can assist with the prior authorization process and can provide documentation required for you to obtain reimbursement. Failure to obtain prior authorization when it is required by insurance will result in the client being financially responsible for the full fee.

No-Show and Cancellation Policies: The charge for missed therapy appointments is \$150. The charge for missed evaluation appointments is \$500. You may cancel an appointment by texting or leaving a message on my voicemail. As long as the message is received **at least 24 hours in advance**, you will not be charged. If you re-schedule the appointment within the same week, you will not be charged the cancellation/no-show fee.

Payment: I accept checks, cash (exact amount please), most major credit cards and Venmo. I can also accept FSA and HSA cards. Bounced checks will result in an additional \$25 charge to cover bank and accounting fees. Timely payment of your bill is considered part of your treatment. Please speak with me if you are having difficulty paying for your evaluation or treatment. If your account with me is overdue and we have not arranged a payment plan, I reserve the right to use legal means or hire a collection agency to collect the outstanding balance. In the unfortunate event that this should happen, the client will be responsible to pay not only the balance of the bill but any fees associated with the hiring of the collection agency. Feel free to ask if you have any questions about this agreement. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Communications: Please use phone, email and text only to communicate around routine matters (e.g., appointment scheduling, payment information, missed appointments) or in case of an emergency. Other questions and information should be discussed in session. This respects both my time and the importance of what you have to say, since much of the impact and meaning of what is said is lost in text, voicemail or email.

Confidentiality of Electronic Communications: Faxes are handled by a HIPAA-compliant, secure fax service. **Other communications over the internet are NOT secure.** Although unlikely, your personal health information can be intercepted by third parties when sending text, email or voicemail. Please do not include in any emails, texts or voicemails any information that you would not want disclosed. Please call and speak to me directly if you wish to share such information.

If you do send me a text or email, I will assume that you are giving me permission to respond to you in that way. I will not use your personal health information or identifiers (other than your phone number or email address) when communicating via email or text.

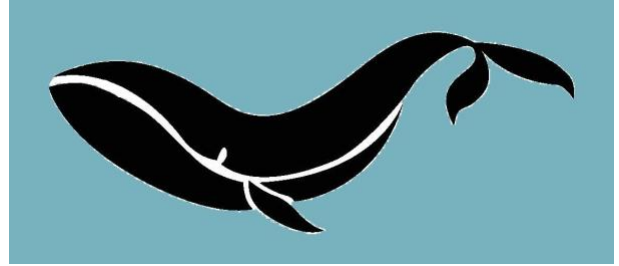
Print Name

Signature

Date

John T. Langfitt, Ph.D., ABPP-Cn

Board Certified in Clinical Neuropsychology
American Board of Professional Psychology
NY State Psychology License 101929
Vermont Psychology License 048.0134720



VIDEORECORDING OF PSYCHOTHERAPY CONSENT FORM

I, _____, hereby grant permission to John Langfitt to video-record my psychotherapy sessions. I understand that he is committed to studying the process of treatment in order to make psychotherapy more effective and efficient. To this end, I agree that these recordings can be used for:
(initial all that apply)

- _____ his personal review
- _____ review and supervision with senior colleagues
- _____ the teaching and training of other health care professionals.

I understand that my full name will never be revealed and these recordings will be treated with the same level of confidentiality as all mental health records. Specifically, these recordings will be maintained on an encrypted, external hard drive that that will be stored in a safe in his home office and will never be connected to the internet.

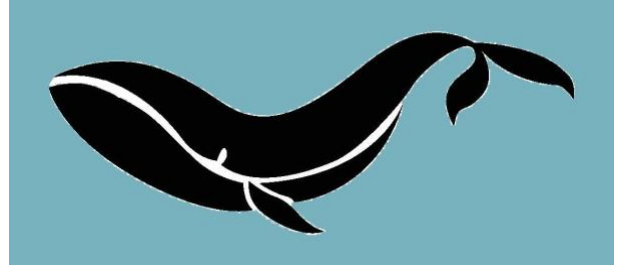
I understand that these recordings are his sole property but that I may retract this agreement, or ask that all recordings be destroyed, at any time.

Date

Name (Print)

John T. Langfitt, Ph.D., ABPP-Cn

Board Certified in Clinical Neuropsychology
American Board of Professional Psychology
NY State Psychology License 101929
Vermont Psychology License 048.0134720



CONFIDENTIALITY IN PSYCHOLOGICAL ASSESSMENT AND TREATMENT

What a patient tells a psychologist has always been treated as private. Our society recognizes that this confidentiality is the foundation of the trust we must have in order for assessment and treatment to be effective. The issue is complicated, however, because there are situations when the law or my professional ethics require me to tell others about our work. Therefore there are some limitations on our confidentiality of which you should be aware. Because a person cannot “unsay” something, it is important to know about these situations at the beginning of our work. These are important issues, so please read these pages carefully. We can discuss any questions or concerns you might have at any point in time.

As is noted above, what is said or done in this work is almost always **confidential**. That is, my professional ethics prevent me from telling anyone else about our work unless you give me written permission to do so. Furthermore, the information shared in therapy is also **privileged**. State and Federal laws protect your right to privacy. These rules are the ways our society recognizes and supports the privacy of what we discuss. There are several specific situations, however, in which confidentiality **may need to be broken**.

If I come to believe that you are at risk for **harming yourself** (e.g., injuring yourself purposefully, intending to attempt suicide) or **seriously harming another person**, I may need to seek hospitalization for you, notify a friend or family member of yours, and/or notify the intended victim and police. In such a situation, I will make every effort to fully discuss my beliefs, concerns, and intentions with you before I do anything. Likewise, if there is an **emergency** in which your life or health is in immediate danger, I may need to release information to another professional in order to protect your life. Due to the emergency, I may need to do this prior to obtaining your permission. If I am unable to obtain your permission, I will discuss this situation with you as soon as possible afterwards. If I suspect that a **child or older adult** is being **abused**, I am required (as a “Mandated Reporter”) to file a report with the appropriate state agency. I do not have the authority or legal responsibility to investigate the situation in order to determine additional facts. I am obligated to report even suspicion of abuse. The appropriate agency will then investigate and will determine whether or not abuse has occurred. Under State law, I cannot be held liable for a report filed in good faith. Again, I would speak with you about any concerns I have and would work with you to take the appropriate action.

In all of these situations, I would only reveal the amount of information necessary to protect you or the other person. I will not discuss everything you have told me. If any of these potential situations concern you, please notify me so we can discuss them in greater detail.

Privileged Communication

In general, if you become involved in court proceedings, you can prevent me from testifying about the therapy. This is called “privilege” and it is always your choice to invoke it or waive it (i.e., allow me to testify). There are some situations, however, where the judge may require me to testify because the judge believes the court needs my information to make a reasonable decision:

1. In child **custody** or adoption proceedings where your fitness as a parent is questioned or in doubt.
2. During a **malpractice** case or a disciplinary board hearing against a therapist.
3. In a civil **commitment hearing** where you might be admitted to a psychiatric hospital.
4. When you are seeing me for **court-ordered psychological evaluations or treatment**. In this case we need to discuss confidentiality fully because you have the right to not tell me what you do not want the court to know.
5. **Confidentiality of Electronic Communications**: Faxes are handled by a HIPAA-compliant, secure fax service. Other communications over the internet are NOT secure. Although unlikely, your personal health information MAY be intercepted by third parties when sending text, email or voicemail. Please do not include in any emails, texts or voicemails any information that you would not want disclosed. Please call and speak to me directly if you wish to share such information. If you do send me a text or email, I will assume that you are giving me permission to respond to you in that way. I will not use your personal health information or identifiers (other than your phone number or email address) when communicating via email or text.

Additional issues related to your confidentiality

1. I may sometimes **consult** with other professionals about your evaluation or treatment. I will not reveal your name, and the other professional is also legally bound to maintain the confidentiality of your information. Similarly, when I am out of town or unavailable, another therapist will be covering my practice in case of emergencies. I must give him or her some information about patients who may have difficulties so that they can adequately handle these crises.
2. I am required to keep **treatment records** of your treatment. You are entitled to review these records with me if you wish.
3. If you use your **health insurance** to pay a part of my fees, I am required to give the insurance company some information about your therapy. They usually want to know at a minimum what my diagnostic impressions are, my fee, dates of treatment, treatment plan, and/or a summary of treatment. While I believe the insurance company will act ethically and legally in maintaining your confidentiality, I cannot control access to this information once it leaves my office. In addition, please be aware that I employ an electronic billing service to submit claims to the insurance company on your behalf. That billing service has agreed to abide by the strictest adherence to the aforementioned confidentiality standards.
4. If you have been referred to me by **your employer** or your employer's Employee Assistance Program, I may have to give them some information. If this is your situation, we will discuss fully my agreement with your employer before we talk further.
5. If your account with me is overdue and we have not arranged a payment plan, I can use legal means to collect. The only information I will give to the court, a collection agency or a lawyer would be your name, address, that we met for "professional services", and the amount due to me.
6. Any information that you share outside of therapy (i.e., voluntarily and publicly) will not be considered protected or confidential by a court.
7. If you want me to send information about our therapy to someone else, you must sign a **Release of Information** form. A copy of this form is on my website, under 'Forms.'

The signatures here attest to the fact that we each have read, discussed, understand and agree to abide by the points presented above.

Patient:	_____	John T Langfitt, PhD, ABPP-Cn
	PRINT NAME	
Signature	_____	_____
Date	_____	_____

John T. Langfitt, PhD, ABPP
2 South Main St., Randolph VT 05060
www.johnlangfittphd.com

Authorization for Release of Behavioral Health and/or Medical Information

Patient Name: _____ Date of Birth: _____

I authorize that the requested information may be released to received from:

Name of Person/Provider/Organization/Facility or Program	Contact Name for Organization/Facility/Program
Address	City, St, Zip code
Phone	Fax

I authorize that the requested information may be released to received from:

John T. Langfitt, PhD	2 S. Main St.
(585) 831-1461	Randolph, VT 05060
Phone	Fax

PURPOSE OF THIS REQUEST (Check one): Healthcare Insurance Coverage Discharge Planning
 Housing Disability Determination Personal Other _____

TYPE OF INFORMATION AUTHORIZED: Drug/Alcohol Evaluation and/or treatment Psychiatric Evaluation and/or treatment
 Medical Evaluation and/or treatment

TYPE OF RECORDS REQUESTED: Inpatient: date(s) _____ Outpatient: date(s) _____
 Other: date(s) _____

Specific Information (select one or more as appropriate):

<input type="checkbox"/> Assessments	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Laboratory Test Results _____
<input type="checkbox"/> Diagnostic Impression	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnostic Test Results _____
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Educational Information	<input type="checkbox"/> Other <u>Neuropsychological testing</u>
<input type="checkbox"/> Treatment summary (include history/physical, laboratory tests and x-ray reports) _____		
<input type="checkbox"/> Entire copy of the inpatient/outpatient record checked above _____		

One Time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified above. My authorization will expire:

- When the requested information has been sent/received.
- 90 days from this date
- Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire

- When I am no longer receiving services from Dr. Langfitt
- One year from this date
- Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to the address above, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional authorization.
- If the medical record information is not sent to another care provider, there may be a charge for the requested records.

Signature of Patient or Representative: _____

Relationship to Patient (if requester is not the patient): Parent Legal Guardian Other: _____

Patient was asked to sign this authorization and a copy have been provided to him/her: _____