



Pittsboro Pediatric Psychology and ADHD Clinic  
290 East St, Ste 106  
Pittsboro NC 27312-9448  
919-548-5612

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## **1. Notice of Privacy Practices (PPP+ADHD)**

### **PITTSBORO PEDIATRIC PSYCHOLOGY AND ADHD CLINIC**

#### **Notice of Privacy Practices**

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

Pittsboro Pediatric Psychology and ADHD Clinic ("the practice," "we" etc.) is committed to protecting your personal health information. We are required by law to maintain the privacy of health information that could reasonably be used to identify you, known as "protected health information" or "PHI." We are also required by law to provide you with the attached detailed Notice of Privacy Practices ("Notice") explaining our legal duties and privacy practices with respect to your PHI.

We respect your privacy, and treat all healthcare information about our clients with care under strict policies of confidentiality and are committed to following these policies at all times.

PLEASE READ THE ATTACHED DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT Dr. Heather Brewis Scheffler, Pittsboro Pediatric Psychology and ADHD Clinic's HIPAA COMPLIANCE OFFICER, at (919) 548-5612.

#### **DETAILED NOTICE OF PRIVACY PRACTICES**

Purpose of This Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how the practice is permitted to use and disclose PHI about you.

#### **Uses and Disclosures of Your PHI We Can Make Without Your Authorization**

The practice may use or disclose your PHI without your authorization, or without providing you with an opportunity to object, for the following purposes:

**TREATMENT.** This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other healthcare personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

**PAYMENT.** This includes any activities we must undertake in order to get reimbursed for the services that we provide to you, including such things as organizing your PHI, submitting bills to insurance companies (either directly or through a third party billing company), managing billed claims for services rendered, performing medical necessity determinations and reviews, performing utilization reviews, and collecting outstanding accounts.

HEALTHCARE OPERATIONS. This includes quality assurance activities, licensing, and training programs to ensure that we meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

REMINDERS FOR SCHEDULED APPOINTMENTS. We may also contact you to provide you with a reminder of any scheduled appointments and may use your PHI to tell you about treatment alternatives or other health care services or benefits that I offer.

## **Other Uses and Disclosure of Your PHI We Can Make Without Authorization.**

The practice is also permitted to use or disclose your PHI without your written authorization in situations including:

- For the treatment activities of another healthcare provider;
- To another healthcare provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another healthcare provider (such as the hospital to which you are transported) for the healthcare operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For healthcare fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. In situations where you are incapable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care.
- To a public health authority in certain situations (such as reporting a birth, death or disease, as required by law), as part of a public health investigation, to report child or adult abuse, neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease, as required by law;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the healthcare system;
- For judicial and administrative proceedings, as required by a court or administrative order.
- For law enforcement activities in limited situations, such as when there is a search warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law; and
- For research projects, but this will be subject to strict oversight and approvals and health information will be released only

when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law.

## **Uses and Disclosures of Your PHI That Require Your Written Consent**

Any other use or disclosure of PHI, other than those listed above, will only be made with your written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it).

## **Your Rights Regarding Your PHI**

As a client, you have a number of rights with respect to your PHI, including:

**RIGHT TO ACCESS, COPY, OR INSPECT YOUR PHI.** You have the right to inspect and copy most of the medical information that we collect and maintain about you. Requests for access to your PHI should be made in writing to our HIPAA Compliance Officer. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact our HIPAA Compliance Officer. You will only be provided with a copy of Psychotherapy notes to the extent required by law.

We will normally provide you with access to this information within 30 days of your written request. If we maintain your medical information in electronic format, then you have a right to obtain a copy of that information in an electronic format. In addition, if you request that we transmit a copy of your PHI directly to another person, we will do so provided your request is in writing, signed by you (or your representative), and you clearly identify the designated person and where to send the copy of your PHI.

We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

**RIGHT TO REQUEST AN AMENDMENT OF YOUR PHI.** You have the right to ask us to amend protected health information that we maintain about you. Requests for amendments to your PHI should be made in writing and you should contact our HIPAA Compliance Officer if you wish to make a request for amendment and fill out an amendment request form.

When required by law to do so, we will amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information in certain circumstances, such as when we believe that the information you have asked us to amend is correct.

**RIGHT TO REQUEST AN ACCOUNTING OF USES AND DISCLOSURES OF YOUR PHI.** You may request an accounting from us of disclosures of your medical information. If you wish to request an accounting of disclosures of your PHI that are subject to the accounting requirement, you should contact our HIPAA Compliance Officer and make a request in writing.

You have the right to receive an accounting of certain disclosures of your PHI made within six (6) years immediately preceding your request. But, we are not required to provide you with an accounting of disclosures of your PHI: (a) for purposes of treatment, payment, or healthcare operations; (b) for disclosures that you expressly authorized; (c) disclosures made to you, your family or friends, or (d) for disclosures made for law enforcement or certain other governmental purposes.

**RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR PHI.** You have the right to request that we restrict how we use and disclose your medical information for treatment, payment or healthcare operations purposes, or to restrict the information that is provided to family, friends and other individuals involved in your healthcare. However, we are only required to abide by a requested restriction under limited circumstances, and it is generally our policy that we will not agree to any restrictions unless required by law to do so. If you wish to request a restriction on the use or disclosure of your PHI, you should contact our HIPAA Compliance Officer and make a request in writing.

The practice is required to abide by a requested restriction when you ask that we not release PHI to your health plan (insurer) about a service for which you (or someone on your behalf) have paid the practice in full. We are also required to abide by any restrictions that we agree to. Notwithstanding, if you request a restriction that we agree to, and the information you asked us to restrict is needed to provide you with emergency treatment, then we may disclose the PHI to a healthcare provider to provide you with emergency treatment.

A restriction may be terminated if you agree to or request the termination. Most current restrictions may also be terminated by the practice as long we notify you. If so, PHI that is created or received after the restriction is terminated is no longer subject to the restriction. But, PHI that was restricted prior to the notice to you voiding the restriction must continue to be treated as restricted PHI.

**RIGHT TO NOTICE OF A BREACH OF UNSECURED PROTECTED HEALTH INFORMATION.** If we discover that there has been a breach of your unsecured PHI, we will notify you about that breach by first class mail dispatched to the most recent address that we have on file. If you prefer to be notified about breaches by electronic mail, please contact our HIPAA Compliance Officer, to make Pittsboro Pediatric Psychology and ADHD Clinic aware of this preference and to provide a valid email address to send the electronic notice. You may withdraw your agreement to receive notice by email at anytime by contacting our HIPAA Compliance Officer.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we send your PHI to an alternate location (e.g., somewhere other than your home address) or in a specific manner (e.g., by email rather than regular mail). However, we will only comply with reasonable requests when required by law to do so. If you wish to request that we communicate PHI to a specific location or in a specific format, you should contact our HIPAA Compliance Officer and make a request in writing.

## **Internet, Email and the Right to Obtain Copy of Paper Notice**

If we maintain a website, we will prominently post a copy of this Notice on our website and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

## **Revisions to the Notice**

The practice is required to abide by the terms of the version of this Notice currently in effect. However, the practice reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and on our website, if we maintain one. You can get a copy of the latest version of this Notice by contacting our HIPAA Compliance Officer.

## **Your Legal Rights and Complaints**

You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services, if you believe that your privacy rights have been violated.

Individuals will not be retaliated against for filing a complaint.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Heather Brewis Scheffler, PhD, Pittsboro Pediatric Psychology and ADHD Clinic, 290 East St., Suite 106, PO Box 1372, Pittsboro, NC 27312-1372, 919-548-5612

## **Acknowledgement**

I affirm that I have received a copy of this privacy policy. (Print a copy if you wish.) I understand and accept the terms therein.

Type Client's Name as Signature:

Client's Date of Birth:

If Client is Under 18 Years of Age, Type Authorized Representative's Name and Relationship as Signature:



## **2. Informed Consent (PPP+ADHD)**

### **General Information**

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how the relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the Client Consent section at the end of this document.

### **The Therapeutic Process**

You have taken a very positive step by deciding to seek therapy (for yourself or your child). The outcome of treatment depends largely on a client's willingness to engage in this process, which may, at times, result in considerable discomfort. Recognizing, acknowledging, and changing problematic behaviors is difficult and can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your (or your child's) behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

### **Confidentiality**

Except as otherwise provided in the Notice of Privacy Practices, the session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate order for information stated on the order.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best

treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

## **Telemental Health Services**

Telemental health includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. Telemental health also involves the communication of medical/mental health information, both orally and visually, to other health care practitioners.

Clients have the following rights with respect to telemental health:

1. Clients have the right to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which they would otherwise be entitled.
2. The laws that protect the confidentiality of medical information also apply to telemental health. As such, the information disclosed by a client during the course of therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality as listed above. (See also other sections of this policy and HIPAA Notice of Privacy Practices, for more details of confidentiality and other issues.)

The dissemination of any personally identifiable images or information from the telemental health interaction to researchers or other entities shall not occur without the client's written consent.

3. There are risks and consequences from telemental health. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, that: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of medical information could be interrupted by unauthorized persons; the electronic storage of medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, telemental health based services and care may not yield the same results nor be as complete as in-person service. If the psychotherapist believes a client would be better served by another form of psychotherapeutic service (e.g. in-person service), the client will be transferred to that form of service or referred to a psychotherapist in their area who can provide such service. Finally, there are potential risks and benefits associated with any form of psychotherapy, and despite the client's efforts and the efforts of the psychotherapist, the client's condition may not improve and in some cases may even get worse.

4. The client may benefit from telemental health, but results cannot be guaranteed or assured. The benefits of telemental health may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

5. Clients have the right to access their medical information and copies of medical records in accordance with North Carolina law and the business policies of Pittsboro Pediatric Psychology & ADHD Clinic. These services may not be covered by insurance. If there is intentional misrepresentation, therapy will be terminated.

Clients may discuss this information with their psychotherapist, may have it explained verbally, and may have all their questions answered to their satisfaction.

**Client Consent**

By completing this section, I affirm my understanding and acceptance of the information in the document.

Type Client's Name as Signature:

Client's Date of Birth:

If Client is Under 18 Years of Age, Type Authorized Representative's Name and Relationship as Signature:



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### **3. Business Policies & Procedures (PPP+ADHD)**

This brochure provides information about services this practice provides. These policies were established to allow Dr. Scheffler to concentrate her time and energy on providing quality care to her clients while controlling costs by not incurring the expense of support staff. If questions or concerns, please discuss them with Dr. Scheffler.

#### **Appointments**

When you schedule an appointment, that time is reserved for you and cannot be given to anyone else without sufficient notice. Therefore, there is a \$40 charge for missed appointments for cancellations less than 24 hours in advance (unless necessary due to an emergency). MISSED APPOINTMENT FEES ARE NOT REIMBURSED BY INSURANCE.

#### **Implement Whether**

In times of inclement weather, please call Dr. Scheffler's office/cell phone and leave your phone number and a message regarding your availability to travel and/or meet via telehealth. Dr. Scheffler will call you to confirm or to reschedule your appointment. IF YOU DO NOT FEEL YOU CAN TRAVEL SAFELY, PLEASE DO NOT ATTEMPT TO DO SO. There is no late cancellation fee weather-related cancellations if you attempt to contact Dr. Scheffler.

#### **Childcare**

The best way to reach Dr. Scheffler is by calling her office/cell phone, which should allow you to leave a voicemail message if she is not able to take your call. Due to the independent nature of the practice, Dr. Scheffler cannot promise 24-hour availability. If you have an emergency and cannot reach Dr. Scheffler, follow the instructions in the "Emergency/Crisis Services" section.

Childcare/supervision is not available during sessions. You must arrange childcare for children not involved in the therapy session. It is not appropriate for children, including the client, to be in the room during "parent only" meetings, and other children, including siblings, should not be in the room during clinical discussions that do not involve them.

#### **Messages**

#### **Emergency/Crisis Services**

If you have an urgent need at any time and cannot reach Dr. Scheffler, you may call one of the services listed below. Some insurance companies also have nurse/advice lines (check the back of your insurance card). IF YOU HAVE A LIFE-THREATENING EMERGENCY AT ANY TIME, IMMEDIATELY CALL 911 OR GO TO YOUR LOCAL EMERGENCY DEPARTMENT. Note: While all emergency departments provide medical stabilization, not all provide mental health services. If such an emergency department feels that mental health treatment is needed, they will arrange transport to an appropriate facility.

Chatham, Orange, Alamance counties...Cardinal Innovations Access Center...800-939-5911

Lee, Hamett, Moore, Randolph counties... Sandhills Center Access Center... 800-256-2452

Wake, Durham, Cumberland counties... Alliance Behavioral Access Center... 800-510-9132

Chapel Hill... UNC Healthlink Advice Nurse... 919-966-3820

Raleigh... Holly Hill Hospital Assessment... 800-447-1800

Greensboro... Moses Cone Hospital 24-hour Helpline... 336-832-9700

Nationwide... Suicide Prevention Hotline... 800-273-8255 (TALK)

...Or text "HOME" to 741741

Nationwide... Trevor Project LGBTQ+ Hotline... 866-488-7386

## **Insurance**

Mental health services that are deemed "medically necessary" are covered under most health insurance policies. However, some services may not be covered by your policy. Mental health coverage sometimes differs from medical coverage in terms of deductibles, copayments, and preauthorization and may even be handled by a different company. Every policy is different. You should call your insurance company and verify the terms of your mental health coverage in advance of your intake appointment.

You are responsible for payment of your bill in full to the extent the bill is not paid by your insurance carrier. Deductibles are the amount of medical costs that the client must pay before insurance benefits begin. If the relevant deductible has not been met, the client is responsible for the cost of the session (or the contracted rate for that insurance plan, whichever is lower). A copayment and/or coinsurance is required by many insurance plans for office visits, and this copayment and/or coinsurance is due at each visit. In addition, services not covered by your insurance policy, including but not limited to missed appointments, telephone consults, letter-writing, and school visits, are the client's responsibility. Dr. Scheffler cannot accept the responsibility of negotiating settlement of disputed insurance claims.

When the insurance company processes a claim, they send the client and provider an Explanation of Benefits (EOB) or similar notice. This is what determines the insurance coverage and client responsibility for claim. Once this notice is received, Dr. Scheffler will send you an invoice and charge any amount due to the credit card on file. If you have questions about your coverage, please call your insurance carrier. If you have questions about an invoice or a charge from this practice, call Dr. Scheffler.

## **Fees and Billing Procedures**

A current fee schedule is available on the practice website. Fees, or the appropriate patient responsibility, are due at each visit. Cash, checks (payable to "Pittsboro Pediatric Psychology and ADHD Clinic"), credit cards, and HSA/Flex spending cards (for approved expenses) are accepted. Payment plans may be available if needed for large deductibles, noncovered charges, etc.

The practice expects that you will pay your bill promptly. If you have financial hardship, please discuss payment with Dr. Scheffler.

In order to cut down on checkout time and billing expenses, the practice requires a valid credit card be kept on file so that copayments, missed appointment fees, and other charges may be paid automatically. All credit card information will be used for payment purposes only and will be kept secured.

It is this practice's policy that the person who initiates services for a child is the party responsible for payment. The practice does not bill another person (including a noncustodial parent) unless that individual informs the practice in writing of their

willingness to pay for services. This policy is for the practice purposes only and is not meant to alter any court order or custody agreement.

## **Phone Consultations, Document Preparation, and Medical Records Requests**

Time involved in phone consultations, document preparation (e.g., form completion, letter writing), and other services not covered by insurance is charged at the prorated standard therapy rate and is not reimbursed by insurance. A phone consultation occurs when Dr. Scheffler carries on a conversation of a therapeutic, problem-solving, or information-exchanging nature with the client, authorized family member, or another professional (e.g., teacher, doctor, attorney) for whom a consent to obtain/release information has been completed. There is no charge for short phone calls (under five [5] minutes). Document preparation refers to anytime Dr. Scheffler must complete a form or write a letter, memo, summary, or report for you or another individual or agency (A report is included in the charge for formal, standardized testing only)

Fees for medical record request will be charged per NC state regulations.

## **Confidentiality in Work with Children**

If the client is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate consent to treatment or I am legally authorized to initiate and consent to treatment on behalf of this individual. I will provide a copy of the custody and/or guardianship papers upon request.

If Dr. Scheffler is working with your child, she is your child's therapist only, and it is important that your child be able to trust her completely. Therefore, Dr. Scheffler will keep confidential what your child says the same way that she keeps confidential what an adult says. Unless required by law, she will not release specific information that the child provides without their consent (except as outlined in the Informed Consent document); however, she will discuss with you the general nature of your child's therapy, your child's progress, and your participation in treatment.

## **Social Media Policy**

To avoid dual relationships, which are discouraged in the ethical standards of the American Psychological Association (APA), Dr. Scheffler will not "friend," "follow," or otherwise connect with clients or their immediate family members via social media. This includes, but is not limited to Facebook, Twitter, Instagram, Snapchat, LinkedIn, etc. If Dr. Scheffler and a client or their immediate family member should end up in the same group on social media, Dr. Scheffler will treat this as any other public space and will not acknowledge the individual as a patient unless they do so first.

## **Technology and Record Storage**

Standard email and texting (SMS) are not secure means of communication and do not provide adequate protection of Protected Health Information (PHI). However, most people appreciate the convenience of email and texting, especially for scheduling, appointment reminders, and invoices. Dr. Scheffler does not use email or text (SMS) to transmit clinical information without your consent. Dr. Scheffler uses text (SMS) through the Signal app, which provides end-to-end encryption of messages but requires that both users have the app installed. The practice highly recommends that you download and install Signal if you wish to protect your PHI when texting your arrival at the office or exchanging messages to schedule or reschedule appointments. See the "HIPAA Email and Texting (SMS) Consent" to opt in or opt out of using email and/or text (SMS) for these purposes.

Clinical records are stored in an Electronic Health Records (EHR) system where they are stored in a secure cloud environment. Psychotherapy notes (which are provided extra protection) and restricted test materials are stored in paper form in a locked filing cabinet. Occasionally, records will be transferred to Dr. Scheffler's home office for work there. This is

accomplished using the secure cloud service, an encrypted USB drive, an encrypted tablet/laptop computer, or (for paper records) carried personally by Dr. Scheffler.

Archived paper records are stored in a secure off-site location. Records are retained as required by law, currently for seven years after the last contact or for seven years after the client reaches the age of 18, whichever is later.

## **Electronic Signature**

I have reviewed these policies. I understand and agree to abide by them. I understand my rights and responsibilities as outlined. I agree and consent for myself or my dependent to receive services as provided by Heather Brewis Scheffler, PhD, and Pittsboro Pediatric Psychology and ADHD Clinic.

Type client's name here to agree.:

Client's Date of Birth:

If client is under 18 years old, type authorized representative's name and relationship here to agree.:



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#### **4. HIPAA Email/Text Consent (PPP+ADHD)**

HIPAA stands for the Health Insurance Portability and Accountability Act.

HIPAA was passed by the US Government in 1996 in order to establish privacy and security protections for health information.

Information stored on our computers is encrypted.

Most popular email services (e.g., Gmail, Yahoo, Hotmail) do not utilize encryption.

If and when we send you an email, or you send us an email, the information is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once an email is received by you, someone may be able to access your email account and read it.

Email is a very popular and convenient way to communicate for a lot of people, so in a modification to the HIPAA, the federal government provided guidance on email and HIPAA.

The information is available in a PDF (page 5634) on the US Department of Health and Human Services (DHHS) website: <http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>.

The guidelines state that if a client has been made aware of the risks of unencrypted email, and that same client provides consent to receive health information via unencrypted email, then a health entity (provider) may send that client personal medical information via unencrypted email.

If you understand the risks of unencrypted email and give permission to Pittsboro Pediatric Psychology & ADHD Clinic to send you personal health information via unencrypted email, select "I consent to unencrypted email" and provide covered email address(es) in the box(es) below. If you do not wish to receive personal health information via email, select "I do not consent to unencrypted email" and do not provide any email address(es) on this form. You understand that you will not get emailed appointment reminders and that invoices will be sent by US Mail.

Email Consent Selection:

Email address covered by this consent:

Email #2:

Email #3:

Text (SMS) is likewise a very convenient method of communication favored by many clients. Most text (SMS) services also send information unencrypted. Signal is a text (SMS) service that provides end-to-end encryption of information but

requires that both individuals have the app installed on their devices. Pittsboro Pediatric Psychology & ADHD Clinic uses the Signal app when sending text (SMS) messages. If you provide your consent and provide phone number(s) on this form, you agree to install the Signal app on your devices and/or accept the risk of sending and receiving unencrypted information ytext (SMS). If you do not wish to use text (SMS), select "I do not consent to text (SMS) and do not provide any phone numbers on this form.

Text (SMS) Consent Selection:

Phone number(s) covered by this consent::

Type name of client here as signature.:

Client's Date of Birth:

If client is under 18 years of age, type name of authorized representative (and relationship) here as signature.:



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### **5. Credit / Debit Card Payment Consent (PPP+ADHD))**

Patient name:

(Card holder) Name on card if different than patient:

Card Type:

Last 4 digits of card number:

Expiration Date :

I authorize Pittsboro Pediatric Psychology and ADHD Clinic to charge my credit/debit/HSA/flex card for professional services at the time services are rendered or when notice of insurance coverage and patient responsibility (EOB) is received. If I do not show up for an appointment and did not provide the practice at least 24 hours' notice, I recognize that Pittsboro Pediatric Psychology and ADHD Clinic will charge my card the appropriate No Show/Missed Appointment fee according to the current Fee Schedule (available on the practice website).

I verify that my credit card information, provided in full in the payment section of the client portal and abbreviated above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Type name of cardholder here to agree.: