



Christopher J. Quarto, Ph.D., PLLC

Licensed psychologist (HSP)

509 Crossway Ave.

Murfreesboro, TN 37130

(615) 403-5227 chris@chrisquarto.com

chrisquarto.com

OFFICE PROCEDURES, CLIENT INFORMATION, AND DISCLOSURE STATEMENT

Welcome to my practice! I am a licensed psychologist who has specialized training and experience in a number of areas including individual, family, and group therapies for children, adolescents, and adults. As a psychologist, I have extensive experience assessing individuals for Attention Deficit/Hyperactivity Disorder (AD/HD), emotional problems (e.g., depression, anxiety) and learning disabilities. In addition to my part-time private practice, I am employed as a professor in the Department of Educational Leadership (Professional Counseling program) at Middle Tennessee State University.

PSYCHOLOGICAL TESTING: In many cases, clients are referred to me for psychological evaluations by their physicians or schools to assess for AD/HD, behavior disorders, emotional problems and/or learning disabilities. It usually takes 2 hours to complete an evaluation. I spend approximately five hours scoring tests, interpreting the test results, and writing a report, which contains the background information, test results and summary and recommendations. Clients receive written reports within 7 days following the test session. Psychological evaluations are conducted at my clinic or online.

Special note for psychological evaluations that are conducted for the purpose of determining possible test taking accommodations (e.g., ACT, SAT, GRE, Praxis): There are no guarantees I will make a recommendation that you or your child should receive test taking accommodations at the conclusion of my evaluation. This recommendation is made on a case-by-case basis based on historical information as well as test results that justify it.

COUNSELING: Clients are also referred to me for counseling services. Counseling involves two or more people (a psychologist and a client) discussing issues that are causing clients problems at home, school, and/or work and figuring out ways to solve those problems. My role in the counseling process is to listen to you discuss your thoughts and feelings regarding problems and to help you solve problems. Your role is to be open and honest in discussing issues, answering questions, and doing whatever it takes (including “homework assignments” outside of counseling sessions) to solve your problems. Counseling sessions last between 45 and 50 minutes. At this point, I am only providing distance counseling services (i.e.,

videoconferencing). Distance counseling is the delivery of counseling by a licensed mental health professional via secure video or other technology mediums (e.g., phone, chat, email). I only provide these services in a video format (i.e., talking to one another face to face on computer monitors, iPads/tablets, or smart phones). More and more insurance companies are covering the costs of distance counseling services. You can obtain more information about distance counseling by watching this short video clip: <https://www.youtube.com/watch?v=ab2U6i9AXPk>

Counseling is tremendously beneficial to some people; however, there are some risks involved. The benefits of counseling include learning about yourself and various factors that contribute to personal and relationship problems. In addition, I will help you develop methods of resolving problems by teaching you problem-solving skills. Counseling can also be risky when discussing certain issues which make you feel uncomfortable, sad, angry, and/or guilty. It is important to remember that these feelings are a normal part of the counseling process and I will probably be the one who asks questions or makes comments which give rise to these feelings. However, I will stand by you to help resolve issues that are contributing to these feelings.

TERMINATION: Termination of counseling may occur at any time and may be initiated by the client or psychologist. If you decide to discontinue counseling, please inform me of your decision ahead of time and the reasons for your decision. I may decide to terminate the counseling relationship if, in my opinion, my services are not benefiting you and/or if I believe an alternative treatment approach will be of greater benefit to you.

CLIENT RIGHTS: At any time, you may question or refuse counseling or psychological testing procedures or obtain whatever information you wish regarding the services you are receiving. You are assured of confidentiality, except where legally mandated. Specifically, the law requires me to notify parents, guardians, and/or others (e.g., police) if I believe that you have an intention to harm yourself or another individual. I am also obliged by law to report any *suspicion* of child abuse, neglect, or molestation in order to protect the children involved as well as cases involving domestic violence. In legal cases, professional records may be subpoenaed by a judge. Finally, insurance companies require me to provide information regarding clients' diagnoses and dates of service for reimbursement purposes. Confidentiality will be guaranteed in all cases, except as noted above.

CLIENTS WHO ARE DEPENDENTS: I keep confidential what children say to me in the same way I keep confidential adult conversations. As the parent or guardian, you have the right to question and understand the nature of my activities and progress with your child, but I will use discretion in what I disclose to you.

SOCIAL MEDIA POLICY: I do not accept friend or contact requests from clients on any social networking site (e.g., Facebook, LinkedIn) as it is important to maintain professional boundaries with clients. In addition, it is always possible that accepting friend or contact requests could compromise your confidentiality and our respective privacy. Although it is appropriate to follow me on my professional Twitter account, I have no expectation that you will do so (and I

will not follow you back if you do). If you choose to follow me and I recognize your name, then I may briefly discuss this with you and its potential impact on our working relationship.

CHARGES: The charges for my services are based on the usual, customary, and reasonable fee profiles for this area. Fees for counseling are \$150.00 for the initial interview and \$120.00 for subsequent counseling sessions. Fees for psychological testing vary depending on the nature of the evaluation, but typically range between \$600.00 and \$800.00. Visa and MasterCard are acceptable forms of payment. I also submit insurance claims on behalf of clients.

Clients who do not show up for their scheduled appointment or cancel within 24 hours of the appointment will be charged \$75.00.

MENTAL HEALTH INSURANCE: If you have a health insurance plan, your insurance company may cover all or part of the costs of counseling or psychological testing sessions. Here are some guidelines to keep in mind regarding the use of health insurance benefits:

- If your insurance company requires you to pay a percentage of the costs of mental health services, then this must be paid in full immediately following a session. For example, if your insurance plan covered 80% of the costs of a counseling session and the session cost \$120.00, then you would be responsible for paying the other 20% of my insurance contract rate (i.e., what I have agreed to be paid by the insurance company) on the day of the test session (e.g., \$16.00 or 20% of the contracted rate of \$80.00).
- If your insurance company requires you to make co-payments for services, then co-payments must be paid immediately following a counseling or psychological test session.
- If you have a deductible that must be met before your insurance company provides a benefit, then the deductible must be paid in full immediately following a counseling or psychological test session.
- I only submit claims to clients' primary insurance and not secondary insurance. If you have a secondary insurance then I would be happy to provide you with a superbill (i.e., a special receipt) that you can submit to them yourself for possible reimbursement of services.

I contact insurance companies to verify insurance benefits and inform clients of these benefits prior to the first appointment. The standard disclaimer of insurance companies is, "*A quote of benefits is not a guarantee of payment.*" So although an insurance representative will provide me with your benefit information there is no guarantee that the insurance company will pay for my services until I submit a claim to them and they determine that the diagnosis and services rendered are covered under your policy. I submit insurance claims to insurance companies to obtain reimbursement for services rendered. Although I perform this service as a courtesy for clients, the relationship is between you, the client (or client's parent/legal guardian), and your

insurance company. If the insurance company does not pay for my services then you are ultimately responsible for full payment of services rendered in a timely manner.

If you are responsible for paying all or a portion of the bill and I do not receive payment from you in a timely manner (i.e., by the agreed upon due date OR by the due date specified on the statement), then you will be notified by mail or e-mail to pay the bill immediately to avoid having your account turned over to a collections attorney. If you fail to make a payment within a reasonable time period, then the account will be turned over to a collections attorney and you will be responsible for paying the balance due as well as attorney fees associated with collection efforts.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS: When I first talk to you on the phone to schedule your appointment, I will ask you if it is OK to e-mail you information pertaining to your appointment time, interview and psychological testing procedures, and payment information as well as registration and history forms. It is always possible, but unlikely, that someone other than yourself could access this e-mail as most e-mail communications are not secure (i.e., encrypted). This poses a risk to confidential communication. If you give me permission to e-mail you the information, then please let me know at the time of the initial phone call and print an "X" on the appropriate line on page 5 and sign and date where indicated. If you do not give me permission to contact you by e-mail, then please let me know at the time of the initial phone call and print an "X" on the appropriate line on page 5 and, once again, sign where indicated.

Informed Consent Acknowledgement

I have been given a copy of the Office Procedures, Client Information, and Disclosure Statement, and have read, understand, and agree with its contents.

I hereby consent to receive, or have my child receive, counseling or psychological testing services as a client of Christopher J. Quarto, Ph.D., PLLC. I understand that I have a right to withdraw my consent for services at any time. This consent to counseling or testing shall be in effect for the duration that services are rendered by Dr. Quarto or until he specifically withdraws it.

I understand that if I am being evaluated for a learning disability that there are no guarantees that Dr. Quarto will recommend test taking accommodations for me. Such recommendations are made on a case-by-case basis based on historical information as well as test results that justify accommodations.

I authorize Christopher J. Quarto, Ph.D., PLLC to submit insurance claims to my insurance company or the insurance company of the insured. I hereby authorize Christopher J. Quarto, Ph.D., PLLC to furnish information to insurance carriers concerning my diagnosis and dates of services and, if requested by my insurance company, information regarding the reason I am

seeking services and treatment plan (or that of my child). I hereby assign Christopher J. Quarto, Ph.D., PLLC all payments for services rendered to me and/or my dependent(s).

I understand the financial policies of Christopher J. Quarto, Ph.D., PLLC and have been informed of the costs of services. I also understand that a quote of benefits that have been provided to Dr. Quarto by my insurance company (if applicable) is not a guarantee that they will pay for services and I am ultimately responsible for any amount not paid by the insurance company. Finally, I understand that if I do not pay the balance of the account in a timely manner and Dr. Quarto is forced to turn my account over to a collections attorney, I am responsible for paying attorney fees associated with the attorney's collection efforts.

Signature of client

Date

Signature of parent or guardian (if client is minor)

Date

Electronic Transmission of Protected Health Information via E-mail

I _____ DO _____ DO NOT (please place an "X" on one of the preceding lines) authorize Dr. Quarto to transmit the following protected health information from my health records and/or my health care treatment by non-secure means:

- information related to scheduling appointments and what will take place on the day of the appointment (e.g., interview, psychological testing procedures);
- Information related to billing and payment;
- psychological evaluation and/or information related to how to access my psychological evaluation (if this is the service that Dr. Quarto is providing to me) following my appointment;
- other information not specified above with my prior approval.

My authorization to communicate with Dr. Quarto by e-mail includes my verbal authorization when we first spoke by phone. I understand that this authorization will expire two months following my appointment. I also understand that there may be extenuating circumstances in which Dr. Quarto needs to contact me after my authorization has expired and I grant him permission to do so. I understand that all e-mails are retained in the logs of my and Dr. Quarto's Internet service providers and while it is highly unlikely that anyone will look at these

logs, they are, in theory, available to be read by the system administrator of the Internet service provider. In addition, although it is highly unlikely that an “e-mail hacker” will intercept e-mails between me and Dr. Quarto, I understand that the risk exists and give Dr. Quarto permission to send me e-mail by non-secure means.

Signature of client

Date

Signature of parent or guardian (if client is minor)

Date