



Silver State Psychology

Putting Your Child First

INTAKE PACKET CHECKLIST

- Copy of Parent/Legal Guardian's Driver's License
- Copy of Insurance card front and back
- Notice of Information Practices and Privacy Statement (HIPAA)
- Professional Fees, Billing, and Office Policies/Consent
- Medicaid/Private Insurance Fee Agreement and Contract
- Legal Guardianship
- Agreement Between Patient/Silver State Psychology
- Patient/Parent Information Form
- Covid-19 Consent Form
- Child Neuropsychological History form
- Records (reports, evaluations, report cards, Multidisciplinary Team Evaluation Reports, Individualized Educational Programs)



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NOTICE OF INFORMATION PRACTICES AND PRIVACY STATEMENT (HIPAA)

When you sign our fee agreement and consent form, you are giving us permission to release your Personal Health Information (PHI) for the following purposes:

1. **Assessment/Treatment:** Only within our offices. Any discussion with outside health care providers or educational institutions/agencies requires your explicit written permission.
2. **Standard Office Practice:** Scheduling appointments, record-keeping, phone calls, etc.
3. **Research Purposes:** Unless your explicit consent is obtained, no identifying information will be used for research, only archival data which has been aggregated.
4. **Payment:** The basic minimum information to your insurance company, funding agency (if applicable) or other third party as necessary for approval, payment authorization, and billing.

Any other release of your PHI requires your permission.

Exceptions: Silver State Psychology may release confidential information **without** your consent if:

- Reasonable suspicion of child abuse, elder, and/or sexual abuse
- Serious threats to health or safety
- Court order or subpoenas
- Licensing Board investigations
- Other applicable laws including the PATRIOT Act and other state/federal laws

Patients' Rights: You have the right to:

- Put restrictions on disclosures
- Receive a listing of disclosures made (except as provided by the PATRIOT Act/Federal Law)
- Request and receive a full copy of the privacy policy
- Submit a request to inspect, copy or amend your records (in coordination with your psychologist)

Psychologists' Responsibilities: We are committed to maintaining the privacy of your PHI and will notify you of any changes in our privacy policies and practices. Please note that under HIPAA, your psychologist has the right to deny your request to inspect, copy, or amend your records, but will make every reasonable effort to discuss this with you.



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Copies of Records: Copies of records will be provided in accordance with state law; fees may be charged for copying/mailling and/or inspection of records. Originals will be maintained by Silver State Psychology.

Electronic Media/Communications: Silver State Psychology cannot ensure the privacy of communications via electronic mail, text messages, and other electronic methods. Any email or text message, although intended to be private, is under the control of the service provider and is not under the control of Silver State Psychology. It is advised that no full names should be used in these communications, and all confidential documents should be password protected or encrypted. Facsimile communications and restricted delivery mail are the most secure method of transmitting documents. Facebook and other social media sites will not be used to communicate any client information.

Minors/Conserved Adults: At the outset of the case, the responsible party/adult will be identified. If a child reaches the age of majority during or after the evaluation is completed, the authorization reverts to the client unless the client is conserved.

Joint Custody: Parent with custody agreements/decrees are advised to seek legal advice regarding the disclosure of information, and ability to consent or block consent, by the non-custodial parent.

Rescinding Authorization to Disclose: Parents or adult clients have the right to rescind authorization to disclose information at any time; this rescission should be made in writing, with a verbal statement for expediency.

Privacy Complaints: If you feel we have violated your privacy rights, please contact:

HIPAA Compliance Officer at Silver State Psychology

Effective Date: This statement is effective as of May 1, 2019



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PROFESSIONAL FEES, BILLING, AND OFFICE POLICIES

Thank you for choosing Silver State Psychology as your provider. Dr. Ivan Hronek and his front office staff are available to answer any questions you may have about our clinical services or financial policies.

Cancellations: If you should need to cancel a scheduled appointment, please notify our office at least 24 hours in advance, so that we may accommodate families who are on our waiting list for an earlier appointment. Failure to cancel your appointment within 24 hours will result in a charge of \$35.00. Failure to cancel your appointment within 24 on two separate occasions will result in all future appointments being cancelled.

No-Shows: If you fail to attend a session and do not inform the office in advance, all your future appointments will be cancelled.

Tardiness: Please note that if you arrive for your appointment up to 15 minutes late, you will be seen, but the appointment may end at the scheduled time. If you are more than 15 minutes late, your appointment will be rescheduled.

Record Retention: The State of Nevada requires behavioral health providers to maintain records of patients seen as children until they turn 23 years of age. Records of patients seen as adults will be maintained for 5 years after last seen by Silver State Psychology.

Medical Emergency: If you are experiencing a medical emergency, please call 911, contact your primary care provider, or proceed to the nearest emergency room.

Communication Outside of Appointments: Please note that Silver State Psychology providers may not be immediately available to be reached by telephone. If your question can not be answered by front office staff, please leave a message, and your call will be returned within 2 business days.

Payment: Silver State Psychology accepts cash, credit cards, and checks. If you choose to pay by credit card, you will be charged an extra 3.5% fee. You will be expected to pay all money due, including insurance co-payments, unpaid deductibles, and any other applicable fees, at the time of service. There are no refunds under any circumstances.

Silver State Psychology makes every attempt to verify patients' insurance benefits; however, an authorization and quote of benefits we receive from an insurance company is **NOT** a guarantee of payment from your carrier. If the actual benefit is different, you will be billed the remaining balance or refunded credit, which may be up to approximately \$1400, depending on your insurance plan. Please understand that you are financially responsible for any balance not covered by your insurance plan. Parents/patients are responsible for understanding their own insurance plans. CPT codes that may be used include 90791, 96132, 96133, 96136, 96137, 96138, 96139, 96130, and 96131.



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Services: Patients may be seen by Dr. Ivan Hronek, Dr. Antrice Hronek, a licensed psychologist employed by Silver State Psychology, or a postdoctoral/predoctoral fellow/intern. Dr. Hronek may employ a psychometrist to assist with test administration. There will be a total of 3 sessions. First, there is an intake interview lasting 1 hour. This session is just for parents and legal guardians, during which parents share their concerns about their child. Next, the child is brought for the comprehensive neuropsychological evaluation. Please note that parents are required to wait in the lobby during the course of the evaluation unless other arrangements are made with the examiner. Parents may not be present in the examination office during the evaluation, as this would invalidate the results.

Legal Proceedings: Silver State Psychology does not provide any services for the purposes of litigation and/or for forensic issues. If you become involved in legal proceedings that require the participation of Dr. Hronek, or any other staff at Silver State Psychology, you will be expected to pay for all of his professional time, including preparation and transportation costs, even if he is called to testify by another party. Charges for this service are \$375 per hour. Legal guardians are to instruct their attorneys not to subpoena Dr. Hronek or other staff of Silver State Psychology.

Collections: If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, Silver State Psychology has the option of using legal means to secure payment. This may involve hiring a collection agency which may require Silver State Psychology to disclose information that would otherwise be confidential. In most situations, the only information released is a patient's name, the nature of services provided, and the amount due. For checks written to Dr. Hronek from accounts that have insufficient funds, a \$50 returned check processing fee will be charged to you.

Raw Data: Please note that raw test data is typically not provided to parents and legal guardians, due to the risk of misinterpretation, and the risk of the test data becoming public.

Superbill: For patients covered by insurance companies not contracted with Silver State Psychology (out-of-network), patients are responsible for all charges at the time of service, and will be provided with a superbill, which they may send to their insurance company. Please note that Silver State Psychology makes no claim that your insurance company will cover the cost of services provided.

Fee Schedule: The standard fee for a standard neuropsychological evaluation for an individual between the ages of 6-25 years old is \$2100. Psychological Testing rates are \$175 per hour. Silver State Psychology does not offer a sliding scale, but we do offer a payment plan. All payment is agreed upon and due at the time of service and is non-refundable.



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CONSENT

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your professional relationships with Dr. Hronek and other Silver State Psychology staff for your child's evaluation. At your request, Silver State Psychology would be glad to provide you with a copy of this document for your records. Your signature below also serves as an acknowledgement that you have received and read the HIPAA Notice Form.

Your Name (Print): _____

Your Relationship to the Minor Child: _____

Signature

Date: _____

Staff Signature

Date: _____



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FEE SCHEDULE

(FOR PATIENTS NOT USING THEIR INSURANCE)

Fee for complete Neuropsychological evaluation/assessment: \$2,100

The above fee schedule is active as of August 12, 2022.

Please note that the agreed-upon fee schedule is due at the time of service and cannot be changed retroactively.

Payment plans are available.

MEDICAID/PRIVATE INSURANCE FEE AGREEMENT

Dr. Hronek is a contracted provider with a variety of private insurance plans, including but not limited to: United Healthcare (UHC), Aetna, Tricare (HNFS), HPN, HPN/Medicaid, SHL, Cigna, UMR/UHC Choice Plus, and Culinary Health Fund. If a patient is receiving services through their insurance, our office will bill their insurance plan directly for services that we provide to you.

Verification: Silver State Psychology staff will need to verify the patient's enrollment and eligibility prior to each appointment. Neuropsychological services may require a referral and a prior authorization request (PAR) prior to the provision of services. Patients (or parents/guardians) agree to cooperate with Silver State Psychology staff to ensure insurance coverage of all services.

Responsibility for Fees: If patient's insurance/NV Medicaid enrollment ends or their eligibility for benefits status ends, patients are responsible for all fees for services provided after the date of the change.



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MEDICAID/PRIVATE INSURANCE FEE CONTRACT

By signing below, you acknowledge you have received and reviewed the information contained in this document. Should you have any questions, please contact Dr. Hronek or his front office staff. You acknowledge that you are responsible for all fees not covered by your private insurance/Nevada Medicaid Fee-for-Service or Nevada Check Up.

Patient Name: _____ DOB: _____

Printed Name of Parent or Legal Guardian

Signature

Date: _____

Printed Name of Parent or Legal Guardian

Signature

Date: _____

Staff Signature

Date: _____



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LEGAL CUSTODY OF MINORS

It is the policy of Silver State Psychology that all parties with legal custody of a minor agree to their participation in psychological services. By signing below, you are acknowledging this policy and indicating you are authorized by all parties to initiate psychological services for your child.

Joint legal custody: If you are not fully authorized to initiate psychological services for your child, please notify me. Evaluations may not proceed until all legal guardians agree to services.

Your signature below shows that you understand the office policies described above, and that you have legal custody/legal guardianship of the child, and therefore, the right to seek out psychological services for the child.

Patient Name: _____ DOB: _____

Printed Name of Parent or Legal Guardian

Signature

Date: _____

Printed Name of Parent or Legal Guardian

Signature

Date: _____

Staff Signature

Date: _____



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AGREEMENT BETWEEN PATIENT/SILVER STATE PSYCHOLOGY

Thank you for choosing our practice. We strive to provide a respectful and comfortable environment for children and their caregivers, regardless of their race, ethnicity, gender identity, religious identity, economic status, educational background, marital status, or source of payment for care.

Please be advised that our practice's policies regarding your information are outlined in the Notice of Information Practices and Privacy Statement (HIPAA) form.

We agree to provide all services in a confidential manner. Patient privacy will be respected and maintained. You have the right to access information contained in your records, except in certain circumstances described by law.

We will require your written consent for us to share any of your child's information to anyone not directly involved in their care, except as otherwise required by law.

We will provide you with an estimate of the cost of your child's evaluation.

Silver State Psychology will explain the results of their child's evaluation to parents in terms that are understandable to them.

Patients are to be considerate of office property and testing material. Destruction of office and/or test material will not be tolerated and may result in termination of the evaluation.

Patients are to provide Silver State Psychology with accurate information about their insurance status and with accurate information about their child's behavior, functioning, and symptoms.

Payment is expected at the time when services are rendered. Silver State Psychology accepts payment by cash, credit card, or check.

Patient Name: _____

Parent/Legal Guardian Name: _____

Signature

Date: _____

Staff Signature

Date: _____



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PATIENT INFORMATION

Patient Name: _____ Age: _____ D.O.B. _____
Gender: M F Other: _____ Preferred pronouns: He/Him She/Her They/Them
Address: _____
School & Grade: _____

PARENT/LEGAL GUARDIAN INFORMATION

Primary Phone: _____ Alternate Phone: _____
Parent Marital Status: _____ Email: _____
Parent/Legal Guardian Name: _____
Employer & Occupation: _____ Work Phone: _____
Employer's Address: _____
Parent/Legal Guardian Name: _____
Employer & Occupation: _____ Work Phone: _____
Employer's Address: _____

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insurance Phone: _____
Member #: _____ Group #: _____
Primary Holder Name: _____ Primary Holder DOB: _____
Relationship to Patient: _____

Secondary Insurance: _____ Insurance Phone: _____
Member #: _____ Group #: _____
Secondary Holder Name: _____ Primary Holder DOB: _____
Relationship to Patient: _____



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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 HEALTH CRISIS

This document contains important information about in-person services considering the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, my other staff, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature and your child's temperature before coming to each appointment. If it is elevated (100°F or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I will not charge you our normal cancellation fee.
- You and your child will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.
- You and your child will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You and your child will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you will not move chairs or sit where we have signs asking you not to sit.
- You and your child will keep a distance of 6 feet and there will be no physical contact (e.g., no shaking hands) with me or staff.
- You and your child will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me and my staff know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me and my staff know.

Changes may be made to the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.



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My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, my staff, and all of our families safe from the spread of this virus. If you show up for an appointment and I or my office staff believe that you or your child have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or my staff test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you or your child have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I must report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

Parent/Legal Guardian Name: _____

Parent Signature

Date: _____

Staff Signature

Date: _____