

ACCESS Psychological and Psycho-Educational Evaluations



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Fax: 501-217-8636



Comprehensive, Multi-Disciplinary Assessments

The ACCESS Evaluation and Resource Center (AERC) offers comprehensive psychological and psycho-educational assessments for individuals ages birth to young adulthood. Clients are assessed for learning disabilities such as dyslexia or dysgraphia, Attention Deficit Disorder, Non-Verbal Learning Disorder, executive functioning problems, Autism Spectrum Disorder, or behavioral and emotional difficulties, such as anxiety or depression. Testing also establishes a learning profile in order to assist with educational programming and to find the most appropriate remediation, accommodations, and compensatory strategies.

The AERC offers a quick admissions process, which includes verification of possible insurance. We are in-network with several private insurance companies; however, not all psycho-educational services are covered.

A comprehensive evaluation includes an interview with the parents or caregivers; review of information obtained from teachers and therapist via questionnaires, previous evaluations, and school records; a full day of testing; a conference with the parents or caregivers to discuss the results of the assessment; and a written report within 15 business days. If recommended, a consultation for academic therapy or supportive technology is included.

Additional services that can be provided are: speech and language evaluation, occupational therapy evaluation, physical therapy evaluation, consultation with the school, academic therapy, cognitive-behavioral therapy, parent training, and working memory training (Cogmed).

General Information

We Serve individuals ages birth-26

Our Team includes:

Sabine S. Falls, Ph.D., Clinical Psychologist

Kimberly Newton, MS, LPE-I

Amanda Driedric, MS, CCC-SLP

Christine Williams, B.S.E., Reading

Specialist Chelsea Cooper, B.S.E., ECSE

Janice Edmonson, MS, CCC-SLP, CALT

ACCESS Psychological and Psycho-Educational Evaluation Fees

Download an ACCESS Psychological and Psycho-Educational Evaluation appointment package at AccessGroupInc.org.

ACCESS Psychological and Psycho-Educational Evaluation fees cover the costs of evaluating clients up to age 26 for various delays and disorders. Fees include a diagnostic interview, testing, a feedback session during which results and recommendations are discussed with the parents, and a comprehensive written report. All fully completed evaluations include a free, one-hour academic and technology consultation, if recommended by the ACCESS clinical psychologist or psychological examiner. These costs may be covered or supplemented by insurance coverage. ACCESS can check client insurance benefits.

Fee Structure:

Comprehensive Psychological Evaluation: \$1,600

Partial Evaluation (half day) \$1100

IQ Testing Only: \$500

IQ Testing with Adaptive testing: \$700

Cogmed Working Memory Training: \$1200

ACCESS Academic Therapy Fees: \$67-77 (depending on place of service)

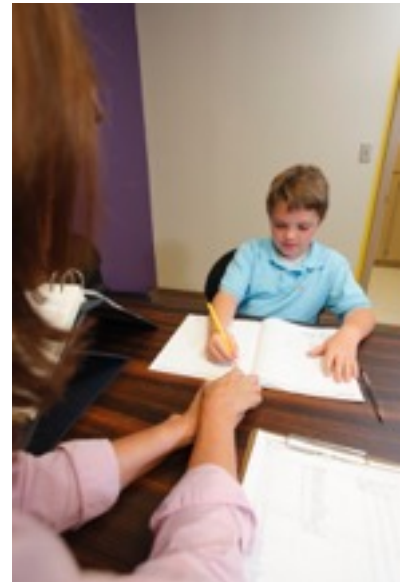
Technology Consultation Fees: \$100

Services that are covered by insurance, CPT codes will be used:

Diagnostic interview: \$250

Psychological Testing: \$160 per hour (Includes scoring, report writing)

Psychotherapy: \$130 per session (45 minutes) a 20% discount applies when paid on the day of service.



ACCESS® Psychological/Psycho-Educational Evaluation Admissions Package Checklist

The ACCESS Evaluation and Resource Center provides comprehensive developmental, psychological and psycho-educational diagnoses and rule-outs for children and youths ages birth to young adulthood. Our multi-disciplinary team of professionals has the benefit of regular exposure to children with learning differences in their therapeutic and educational environments. Their knowledge reaches beyond diagnostics to real-world applications and recommendations. ACCESS Evaluation and Resource Center clients may also benefit from academic therapy, cognitive-behavioral therapy and pragmatics (social skills) groups.

A completed ACCESS Psychological/Psycho-Educational Evaluation admissions package contains:

- ACCESS General Information and Insurance Form
- Developmental History
- Copy of Insurance Card
- Receipt of Notice of Privacy Practices Written Acknowledgement Form
- Financial Policy Form (Please choose Insurance Coverage OR Flat Rate)
- Consent to Treat Form
- Copy of Evaluations and Goals (If Previous Services Were Received)
- Copy of Grades and Standardized Tests (If Applicable; For Students in First Grade or Older)
- Handwriting Sample (If Applicable; For Students in Kindergarten or Older)
- Tutor/Therapist Questionnaire(s) (If Applicable)
- Teacher Questionnaire(s) (If Applicable)

Please return your completed package to:

Admissions Coordinator
ACCESS
10618 Breckenridge Dr.
Little Rock, AR 72211
admissions@accessgroupinc.org
501-217-8600 Phone
501-217-8636 Fax

Once your completed package has been received, we can schedule you and your child for a diagnostic interview. The diagnostic interview is the only financial commitment you have for your first appointment. Once the types of testing needed are determined, we will provide you with the estimated cost for your child's specific testing and subsequent appointments. Please don't hesitate to contact us with any questions at admissions@accessgroupinc.org or 501-217-8600.



Today's Date: _____ Admission Date: _____

Child's Name: _____ Date of Birth: _____

Gender: _____ Race: _____ Home Phone: _____

Home Address: _____
Street City State Zip

Gestational Age: _____

Child's Diagnosis: _____

Child's Primary Care Physician: _____

Child's Social Security Number: _____

Child's Medicaid or Tefra Number: _____

Father's Name: _____ Date of Birth _____

Father's Address: _____

Occupation & Employer: _____

Father's Work Number: _____

Father's Cell Number _____

Email address: _____

Mother's Name: _____ Date of Birth _____

Mother's Address: _____

Occupation & Employer: _____

Mother's Work Number: _____

Mother's Cell Number _____

Email address: _____

Emergency contact name & number: _____

Child lives with: _____ Father _____ Mother _____ Both parents _____ Guardian

This information is current as of the above date. I will notify the office if any changes occur. This information will be updated annually.

Parent/Guardian Signature

date

Program Coordinator

date

MEDICAL INSURANCE INFORMATION

For therapy clients - Please fill this form out in its entirety and provide copies of the front and back of the insurance cards listed below. (The front desk can make copies of your cards if needed)

Student's Full Name _____ SSN: _____
(As shown on Insurance Card)

Parent's Names _____

Address: _____

Race:

- I-American Indian/Native Alaskan
- A-Asian
- B-Black or African American
- P-Native Hawaiian or Other Pacific Islander
- W-White/Caucasian
- E-Other
- 7-Declined

Ethnicity:

- H-Hispanic or Latino
- N-Not Hispanic or Latino
- 7-Declined

Language:

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Polish |
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> French | <input type="checkbox"/> Romanian |
| <input type="checkbox"/> German | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Ukrainian |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Other | |

Primary Insurance Company: _____

Address _____

Policy Holder _____
(As shown on Insurance Card)

Policy Holders SSN: _____ Date of Birth: _____

Policy Number: _____ Group Number _____

Secondary Insurance Company: _____

Address _____

Policy Holder _____
(As shown on Insurance Card)

Policy Holders SSN: _____ Date of Birth: _____

Policy Number _____ Group Number _____

ACCESS Group Inc. will file your insurance for you. However, this does not guarantee that your insurance company will pay for the therapy services. You are ultimately responsible for the payment due on all services.

I hereby authorize ACCESS Group Inc. to furnish information to my insurance company concerning the care of my child. I assign all payments for services rendered to my child to the above. I understand that I am ultimately responsible for the payments due on all services.

Parent/Guardian Signature

Date

My child does not receive therapy services.



Developmental History

Date form completed: _____

I. Identifying Information

Child's Name: _____

Date of Birth: _____

Address: _____

Gender: _____

Street

City

State

Zip Code

County

Parent(s) or Guardian(s): _____

Home Telephone #: _____ E-Mail: _____

Other Telephone #'s (work, cell, etc.): **Parent 1** _____ **Parent 2** _____

School/Preschool (daycare): _____ Grade: _____

Who referred you to ACCESS? _____

Person completing this form and relationship to child: _____

II. Family Information

Parent 1 Name: _____

First

Last

Date of Birth: _____

Lives in home: Yes No

Occupation: _____

Employer: _____

Highest school grade completed: _____

Status of parental rights: _____

Current marital status of parents: _____

If divorced, is **Parent 1** remarried? Yes No

If yes, name of step-parent: _____

Parent 2 Name: _____

First

Last

Date of Birth: _____

Lives in home: Yes No

Occupation: _____

Employer: _____

Highest school grade completed: _____

Status of parental rights: _____

Date divorced, if applicable: _____

If divorced, is **Parent 2** remarried? Yes No

If yes, name of step-parent: _____

How often does your child visit the non-residential parent/guardian? _____

DHS caseworker name and phone #, if applicable: _____

Is your child adopted? Yes No If yes, what was your child's age when adopted? _____

If your child was adopted, was he/she adopted from a country other than the United States? Yes No

If yes, what country? _____

List all persons living in the child's home:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

III. Parental Concerns

A. What do **you** think the issues are with your child? _____

B. What concerns about your child have been expressed by doctors, teachers, others? _____

C. What results would you like to see from your child's evaluation, therapy, and/or school? _____

IV. Pregnancy History

This child's birth order: _____

The number of mother's other children: _____

During this pregnancy, did the mother have illnesses or medical problems? Yes No

Complications and/or medications administered during pregnancy:

V. Birth Information

Length of pregnancy: _____

Age of Mother at delivery: _____

Length of labor: _____

Was labor induced? Yes No

Labor complications: _____

Birth was: Vaginal Cesarean
 Breech Twins or Multiples

Did Mother experience complications? _____

Is your child: Bottle weaned? Yes No

Pacifier weaned? Yes No

Birth weight: _____

Did the baby need medical assistance in starting to breathe? _____

Were there other complications with the baby?

How long did the baby stay in the hospital after birth? _____

Did the baby have health problems in the first six months after birth? Yes No

If yes, please describe: _____

VI. Medical History

A. List any serious illnesses, injuries or hospitalizations your child has had (*include dates*): _____

B. List any surgeries your child has received (*include dates*): _____

C. Has your child had any fevers above 104°? Yes No If yes, when? _____

D. Has your child ever had a seizure? Yes No If yes, when? _____

E. List any **current** medications your child is taking, how often, dosage, for what condition, and for how long:

_____	_____
_____	_____
_____	_____
_____	_____

F. List any past medications your child **has previously** taken, how often, dosage, for what condition, and for how long:

_____	_____
_____	_____
_____	_____
_____	_____

G. Do you have concerns about your child's hearing? Yes No List date of last hearing exam and results: _____

If hearing loss has been identified, does your child have a hearing aid(s) or cochlear implant(s)? Yes No

If yes, explain: _____

H. Do you have any concerns about your child's vision? List date of last vision exam and results: _____

Does your child wear glasses? Yes No If yes, explain: _____

I. Is your child frequently sick or does he/she have any other ongoing medical needs? Yes No

If yes, explain: _____

J. Are your child's immunizations up to date? Yes No If not, explain: _____

VII. Child's Growth and Development

When did your child develop the following skills?

Made sounds _____

Used single words _____

Used simple phrases _____

Sat alone _____

Toilet trained: Daytime _____

Toilet trained: Nighttime _____

Crawled _____

Walked alone _____

Is your child understood:

By family members? Yes No

By others? Yes No

Has your child lost any previously acquired skills? Yes No If yes, what and when: _____

Can your child:

Run?

Yes

No

Jump?

Yes

No

Hop?

Yes

No

Catch a ball?

Yes

No

Skip?

Yes

No

**Ride a
tricycle/bicycle?**

Yes

No

**Hit a ball with a
bat?**

Yes

No

Climb stairs?

Yes

No

Is your child clumsy? Yes No If yes, explain. _____

What is your child's primary language? _____

What is the primary language spoken in your home? _____

Does your child communicate and understand as much and as clearly as his same age peers? Yes No

If no, explain: _____

What is your child's current reading level? _____

Does your child attend and stay focused through:

Dinner?

Yes No

Trips to the grocery store?

Yes No

Meals in a restaurant?

Yes No

If no, explain: _____

Does your child lean excessively on tabletops when sitting? Yes No

Does your child require frequent rest breaks while playing? Yes No

Does your child have difficulty with finishing work in class? Yes No

Does your child have difficulty staying in seat when asked? Yes No

Is your child overly sensitive to certain stimuli such as bright lights, crowds, noises, tags in clothing, movement, hair washing, nail cutting, etc.? Yes No

If yes, describe: _____

Does your child take excessive movement risks (jumping, falling, spinning, etc.)? Yes No

If yes, explain: _____

Are there concerns about your child's height, weight, growth, eating habits, nutrition, or sleeping habits?

Yes No If yes, explain: _____

Does your child choke, gag or cough when he/she is eating or drinking? Yes No

If yes, explain: _____

Has your child ever had a swallow study? Yes No If yes, what were the results? _____

Do you consider your child to be a picky eater? Yes No If yes, explain: _____

Does your child get lost easily or have difficulty finding his/her way? Yes No

If yes, explain: _____

VIII. Child's Mood, Temperament, and Behavior

A. Which of these describes your child now? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Negative self-statements | <input type="checkbox"/> Inhibited responses |
| <input type="checkbox"/> Excessive responses | <input type="checkbox"/> Flat/bland expression |
| <input type="checkbox"/> Excessive worrying | <input type="checkbox"/> Fearfulness/phobias |
| <input type="checkbox"/> Physical complaints without cause | <input type="checkbox"/> Lack of fear response |
| <input type="checkbox"/> Outbursts without obvious reason | <input type="checkbox"/> Difficult to console |
| <input type="checkbox"/> Recurrent nightmares | <input type="checkbox"/> History of abuse/trauma |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Tearfulness |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Tantrums | |

Elaborate as necessary: _____

B. Behavior

Do you have problems with your child's behavior? Yes No

If yes, describe: _____

Does anyone else (e.g., school, sitter) have problems with your child's behavior? Yes No

If yes, describe: _____

Does your child have any difficulties getting along with other children? Yes No

If yes, describe: _____

What does your child like to do with his/her free time or as extracurricular activities? _____

IX. School History

A. Please list all schools your child has attended, beginning with any daycare or preschool before kindergarten and ending with your child's current school.

School	Address	Grade or Class Placement(s)	Dates of Attendance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Has your child ever repeated a grade? Yes No If yes, please specify: _____

C. Has your child ever had an IEP or 504 plan? Yes No If yes, when, where, and why? _____

D. Has your child ever been evaluated before, such as by a school, clinic, speech pathologist or other therapist? Yes No If yes, when and where? _____

*****Please attach copies of any previous test results.*****

E. Does your child currently receive or has he/she ever received any of the following? (Check all that apply and indicate past, current, or both.)

- Speech Therapy: Past Current
- Occupational Therapy: Past Current
- Physical Therapy: Past Current
- Psychotherapy/Counseling: Past Current
- Applied Behavior Analysis (ABA): Past Current
- Special Education services: Past Current

X. Family History

A. Please note below if any of the child's relatives have had any of the following conditions (For example, brother, aunt, cousin, etc.):

	<i>Relationship to child</i>		<i>Relationship to child</i>
Attention problems	_____	Intellectual disability	_____
Behavior problems	_____	Motor or vocal tics	_____
Hyperactivity	_____	Convulsions/seizures	_____
Speech problems	_____	Alcoholism/drug abuse	_____
Language problems	_____	Mental illness (depression, bipolar disorder, anxiety, schizophrenia)	_____
Learning problems	_____		

B. Do any relatives have other conditions? Yes No If yes, please describe: _____

C. Has your family recently experienced any stressful events (for example: deaths, financial worries, marital conflicts)? Yes No If yes, please describe: _____

XI. Other Professionals

A. Please list the names and addresses of other professionals who have worked with you and your family.

	<i>Name</i>	<i>Complete address and telephone number</i>
Primary Care Physician:	_____	_____
Occupational Therapist:	_____	_____
Speech Therapist:	_____	_____
Physical Therapist:	_____	_____
Psychologist:	_____	_____
Psychiatrist:	_____	_____
Other Mental Health Professional:	_____	_____
Others: (please specify)	_____	_____
	_____	_____
	_____	_____

***Please document below any other information you feel will be helpful.

ACCESS Group, Inc.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.**

I, _____, have received a copy of ACCESS Group, Inc.'s
Client's Name

Notice of Privacy Practices.

Signature of Client

Date

Witness, if needed

Date

Signature of Parent/Guardian, if applicable

Date

**DOCUMENTATION OF "GOOD FAITH" EFFORTS
TO OBTAIN WRITTEN ACKNOWLEDGMENT**

A written acknowledgment was not obtained from this client because

___ Client refused to sign.

___ Other – Briefly Explain:

Signature of Employee Completing
Documentation of "Good Faith" Efforts Form

Date

ACCESS GROUP, INC.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A CLIENT OF ACCESS GROUP, INC.) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

ACCESS Group, Inc. is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain at ACCESS Group, Inc. concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by ACCESS Group, Inc.. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that ACCESS Group, Inc. has created or maintained in the past, and for any of your records that we may create or maintain in the future. ACCESS Group, Inc. will post a copy of our current Notice at each facility in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

**Privacy Officer
ACCESS GROUP, INC.
10618 Breckenridge Drive
Little Rock, AR 72211
501-217-8600**

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. ACCESS Group, Inc. may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for ACCESS Group, Inc. – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. ACCESS Group, Inc. may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. ACCESS Group, Inc. may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, ACCESS Group, Inc. may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for ACCESS Group, Inc.. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:

4. Appointment Reminders. ACCESS Group, Inc. may use and disclose your PHI to contact you and remind you of an appointment.

OPTIONAL:

5. Treatment Options. ACCESS Group, Inc. may use and disclose your PHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. Health-Related Benefits and Services. ACCESS Group, Inc. may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. Fundraising. We may contact you to raise funds for ACCESS Group, Inc..

OPTIONAL:

8. Release of Information to Family/Friends. ACCESS Group, Inc. may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

9. Disclosures Required By Law. ACCESS Group, Inc. will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. ACCESS Group, Inc. may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. ACCESS Group, Inc. may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. ACCESS Group, Inc. may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also

may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:

5. Deceased Patients. ACCESS Group, Inc. may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:

6. Organ and Tissue Donation. ACCESS Group, Inc. may release your PHI to ACCESS Group, Inc.s that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. Research. ACCESS Group, Inc. may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the

use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. ACCESS Group, Inc. may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or ACCESS Group, Inc. able to help prevent the threat.

9. Military. ACCESS Group, Inc. may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. ACCESS Group, Inc. may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. ACCESS Group, Inc. may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. ACCESS Group, Inc. may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that ACCESS Group, Inc. communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. ACCESS Group, Inc. will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit ACCESS Group, Inc.' use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. ACCESS Group, Inc. may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. ACCESS Group, Inc. may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for ACCESS Group, Inc.. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. ACCESS Group, Inc. will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by ACCESS Group, Inc., unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures ACCESS Group, Inc. has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in ACCESS Group, Inc. is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests

for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but ACCESS Group, Inc. may charge you for additional lists within the same 12-month period. ACCESS Group, Inc. will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with ACCESS Group, Inc. or with the Secretary of the Department of Health and Human Services. To file a complaint with ACCESS Group, Inc., contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. ACCESS Group, Inc. will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.



Patient Financial Policy

Patient's Name: _____

Commercial Insurance Carriers: We will check your insurance policy to determine eligible benefits for services. This is a service to you and **does not guarantee that your insurance will pay as quoted in the benefit verification process.** We bill most insurance carriers for you if proper insurance information is provided to us. Although we may bill your insurance company for you, the parents or guardians are responsible for the entire amount of each visit and are responsible to make certain all referrals and insurance authorizations are in order for all sessions.

We require payment for deductibles, co-payments and your portion of the services, as figured from your insurance policy, at the time of service. If a refund is due after receiving payment from your private insurance, we will refund that amount to you within 30 days of receipt of payment from the insurance company.

Private Pay: A flat rate of \$1500.00 is due in full at the time of the diagnostic interview. No insurance will be filed.

Methods of Payment: Our office accepts Cash, Personal Check, Master Card and Visa. If not paid according to terms, the parents or guardians understand that our office reports to an outside collection agency.

For returned checks we assess a \$25.00 NSF charge. We report returned checks that are not paid within 2 weeks of being returned to our office to the local district attorney's office.

The parent, guardian and/or responsible party is ultimately responsible for all fees for services. Signature below indicates I have read, understand and agree to the above financial policy for payments of services.

Signature _____ Date _____

Printed Name of above signature _____

Consent for Psycho-Educational Evaluation and/or Treatment

Client _____ DOB _____

I, _____, the undersigned, hereby attest that I have voluntarily agreed to, or given my consent for the minor or person under my legal guardianship mentioned above, a psycho-educational evaluation or treatment with **Sabine S. Falls, Ph.D.** The rights, risks and benefits associated with it have been explained to me.

Non-Voluntary Discharge from Treatment: A client may be terminated non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at ACCESS Group, Inc., and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

Client Notice of Confidentiality: The confidentiality of patient records is protected by Federal and/or State law and regulations. Generally, information that a patient receives services or any information identifying a patient will not be disclosed, unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient at ACCESS Group, Inc. or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is ACCESS Group, Inc.’s duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client’s death, the spouse or parents of a deceased client have a right to access their child’s or spouse’s records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client’s records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information.

I consent to psycho-educational evaluation and/or treatment and agree to abide by the above stated policies and agreements.

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

Witness Date



TUTOR/THERAPIST QUESTIONNAIRE

Sabine Falls, Ph. D.
Psychologist
Phone: 501-217-8600
Fax: 501-217-8636
E-mail: sabine@accessgroupinc.org
Website: www.accessgroupinc.org

IDENTIFYING INFORMATION

Student's Name: _____

Person completing this form: _____ Date: _____

Place of Service: _____ When Started Service: _____

Current Time of Services (ie, # Days and Hours): _____

Telephone # _____ Fax # _____ E-Mail _____

TUTORING/THERAPY INFORMATION

Current areas addressing: _____

Current type of services and programs being done with the student: _____

Current impressions of progress with these interventions: _____

Areas of strength: _____

Areas of weakness: _____

Is the student having any type of behavioral or emotional problems? _____ If yes, please describe: _____

Is the student having any specific problems with memory, attention, activity level, or impulse control? _____

If yes, please describe: _____

In your opinion, what does this student need to better succeed in school? _____

Please write 5 adjectives to best describe this student in your tutoring/therapy setting: _____

***Please use the back of this page for providing any other information you feel will be helpful in evaluating this student.

SCHOOL QUESTIONNAIRE

ACCESS Group, Inc.
ACCESS Evaluation and Resource Center
Phone: 501-217-8600
Fax: 501-217-8636
Website: www.accessgroupinc.org

IDENTIFYING INFORMATION

Child's Name: _____ Grade: _____

School: _____ Teacher: _____

School Address: _____

School Telephone # _____ Fax # _____ E-Mail _____

Person completing this form: _____ Date: _____

ACADEMIC INFORMATION

Current academic subjects and grades over the past two semesters: _____

Any previous grade retentions? _____ If yes, what grade(s)? _____

History of receiving any type of special or remedial instruction for academic difficulties: _____

Primary problems in the school setting: _____

Academic strengths: _____

Academic weaknesses: _____

Are any modifications being made for academic performance? _____ If yes, please describe: _____

Is the student having any type of behavioral or emotional problems? _____ If yes, please describe: _____

Is the student having any specific problems with memory, attention, activity level, or impulse control? _____ If yes, please describe: _____

Is the student having any problems with his/her peer relations? _____ If yes, please describe: _____

In your opinion, what does this student need to better succeed in school? _____

Please write 5 adjectives to best describe this student in the classroom setting: _____

***Please use this page for providing any other information you feel will be helpful in evaluating this student.