Gerard Chambers Jr. Psy.D., Ph.D.
Clinical Neuropsychologist PSY #23778

Neuropsychological & Forensic Assessment Services

Email: gerard@drgchambers.com Phone: 321.208.1554 Fax: 831.325.0125
2140 41st Ave. #200B Capitola, CA 95010 & 1120 McKendrie St. San Jose, CA 95126
NPI#: 1679753156 CA License **PSY#:** 23778

GOOD FAITH ESTIMATE

Good Faith Estimate: We are required by law to provide you what is called a good faith estimate. Dr. Chambers operates on a flat rate regardless of the number of hours he spends on your case. Your financial obligation only changes if there are additional, new, or not agreed upon tasks such as a legal requirement/court related matters or if the case is terminated, at which time a new agreement is needed to initiate new services. A court related matter will have an additional financial and scope addendum. If unanticipated court matters arise, a new agreement is required, and a new good faith estimate will be provided to you.

Contact: If you have questions about this estimate, please contact our office.

Flat Rate Estimate: $4000-$6000 depending upon the services provided to you. Fees are collected before the service are provided, so you will know your costs up front, and they will not change unless legal or other unanticipated or unknown factors arise where the scope of work changes significantly and a new agreement is then required.

You may contact us if the billed charges are higher than the Good Faith Estimate.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to: www.cms.gov/nosurprises or call CMS at 1-800-985-3059.For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

This Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above. **Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed more than $400 than the estimate provided above.**

Initial Here to Confirm Receipt: _____

Gerard Chambers Psy.D., Ph.D.
Clinical Neuropsychologist Psy# 23778
2140 41st Ave. #200B Capitola CA, 95010 &
1120 McKendrie Street, San Jose, CA 95126

Patient Information

Patient's Name: _____

Sex: ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐

Separated ☐ Divorced ☐ Widowed

Home Address: _____

Home Phone: (_____)_____ Cellular Phone:

(_____)_____ Occupation:_____ ☐

Student

Employer (School, if student): _____

Work/School Phone: (_____)_____

E-mail Address: _____

Fax Phone: (_____)_____

RESPONSIBLE PARTY INFORMATION

Parent Name/ Responsible Party:_____

Sex: ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐

Separated ☐ Divorced ☐ Widowed

Home Address: _____

Home Phone: (_____)_____ Cellular Phone:

(_____)_____Occupation:_____ ☐ Student

Employer (School, if student): _____

Work/School Phone: (_____)_____

E-mail Address: _____

Fax Phone: (_____)_____

Spouse's Name: _____ DOB: _____

Intake Questionnaire

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can.

PATIENT IDENTIFICATION

Patient Name _____

Interview Date_____

Phone #_____ Fax # _____ Do we have your permission to release information to the referring professional when it is appropriate? Yes ____ No _____

REASON FOR THE REFERRAL (Please give a brief summary of the main problems)

_____

_____

_____

_____

_____

_____

_____

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General Informed Consent Agreement for psychological/neuropsychological testing/evaluation:

The following agreement relationship is for psychological testing and/or diagnostics and is not an agreement for counseling or continued therapeutic services. Therapy services will be referred to a local provider and signing this agreement acknowledges that fact. **I acknowledge and I agree that I will give *full effort* on all my testing and report symptoms accurately to ensure an accurate result. I acknowledge that my full effort and symptom/historical accuracy is essential during the entire testing process, and I am fully aware that poor effort, exaggeration, inaccuracies, and/or willful withholding of information could adversely affect my results. If I am seeking accommodations, disability, or a legal outcome, I know that there is no guarantee of procuring favorable results and I acknowledge this fact at the outset of services being provided. Also, I know that I must be upfront with sharing accurate information. A lack of sharing accurate information or symptoms could affect diagnostic accuracy. Sometimes the recall of information may be traumatizing. Please let me know if information of this nature exists and we will discuss a path forward to assess it with caution.**

_____
Initials

Fees are due PRIOR TO any services are rendered unless otherwise specified by an insurance agreement or an alternative third-party agreement.

_____
Initials

Confidentiality: All information disclosed within a testing and interview session is protected by state and federal law and ***MAY NOT BE DISCLOSED without your written permission.*** Exceptions of disclosure do exist when state or federal law requires such disclosure, or the referring party requires that confidential material be released for purposes of an evaluation such as a county, state or federal government or private agency including managed care insurance providers and the referring physician/referral source. If a third party is paying for your services, my initials below is a formal agreement to release the information they require unless I change this policy in writing.

_____
Initials

Disclosure by Law: Dr. Chambers must be disclosed certain information by legal and ethical standards: Suspicion, evidence of or disclosure of physical abuse, **sexual abuse or neglect of a child under the age of 18 years.** Dr. Chambers has the obligation to intervene on behalf of a child to prevent forms of abuse as well and there are circumstances where professional judgment may require the reporting of severe emotional abuse of a child.

_____
Initials

Suspicion, **evidence of or disclosure of physical abuse, sexual abuse, neglect, abandonment, isolation and/or financial abuse of an elderly person over the age of 65**. Dr. Chambers has the obligation to intervene on behalf of an elder to prevent these forms of abuse as well and there are circumstances where professional judgment may require the reporting of severe emotional abuse of an elder.

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Initials

Suspicion, **evidence of or disclosure of physical abuse, sexual abuse, neglect, abandonment, isolation and/or financial abuse of a dependent/disabled adult between the ages of 18-64.** Dr. Chambers has the obligation to intervene on behalf of a dependent adult to prevent these forms of abuse as well and there are circumstances where professional judgment may require the reporting of severe emotional abuse of a dependent adult.

_____
Initials

When a patient makes **a serious, threat of violence or death that is an intended threat of violence or death to a reasonably identifiable victim.** The authorities and the victim will be notified in order to prevent such acts. *This applies in cases when a family member reports to Dr. Chambers that a patient on his case load meets the above criteria of harm to others as well.

_____
Initials

In situations where **a patient makes a serious threat of self-harm or suicide Dr. Chambers will intervene to prevent such actions from occurring.** The actions to prevent suicide may include contacting local law enforcement, or a local authority designated by the county. *Please note children under the age of 18 will have a parent notified in suicidal or self-harm circumstances. *This applies in cases where a family member reports to Dr. Chambers that a patient in his care meets the above criteria of suicide or self-harm as well.

_____
Initials

Another circumstance when confidentiality will not be protected is **when a patient presents as gravely disabled.** Grave disability is when an individual cannot provide food, clothing and/or shelter; however, this disability may not be due to mental retardation alone.

_____
Initials

When adult persons that have a history of child abuse, and reveal such abuse, as adults over the age of 18, Dr. Chambers is not mandated to report such crimes. However, **if the perpetrator of this abuse is judged to still have access to children or vulnerable populations, confidentiality cannot be assured and a report will be made to the proper authorities to prevent future abuse.**

_____
Initials

Dr. Chambers discloses information to parents of persons under the age of 18. If parents request confidential information judged to be detrimental to the child or adolescent and/or their care, disclosure to parents will be withheld, and may be challenged by the parent through legal challenges.

_____
Initials

Emergencies: If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care.

_____
Initials

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or third-party payer in order to process claims. If you so instruct me in writing, only the minimum necessary information will be communicated to the carrier. **I have no control or knowledge over what other entities do with the information I submit or who has access to this information.** You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and will also be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

_____
Initials

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Emailed documents can be mistakenly attached inadvertently reveal information to unintended sources. Faxes can easily be sent erroneously to the wrong address. Please notify me in writing if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. For your convenience Dr. Chambers will ask you whether or not you would like to have evaluations emailed. This is a process that expedites the release of your report and subsequent accommodations to you and whomever you designate. As seen in the warning above there is inherent risk to this process. Dr. Chambers will only email to addresses you designate verbally and he uses an encrypted email in most cases. If you prefer only a hard copy or wish to prevent electronic or email transfers of reports, please give Dr. Chambers explicit directions in writing.

_____
Initials

Litigation Limitation: Due to the nature of the assessment process and the fact that it often involves

making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), **neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the records be requested without a separate legal fee arrangement, and the fee itself is not sought to be covered by any managed care company.** You also agree not to seek reimbursement for legal based fees from any third party or insurances and fees are to be paid in advance. I promise not to withhold any information knowingly or unknowingly from Dr. Chambers in regard to past court decisions order, or arrangements made that would affect his ability to assess the patient including decisions in previous custody matters.

_____
Initials

Consultation: I consult regularly with other professionals regarding my clients; however, the client's name or other identifying information is reasonably concealed, if applicable or necessary. I also use other professionals to provide testing that have no professional relationship with you.

_____
Initials

**Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between evaluation sessions, please leave a message on my answering machine (321.208.1554 or 321.298.8668) and your call will be returned as soon as possible. I check my messages a few times a day, unless I am out of town. If you call my answering machine at any time in an emergency, please indicate it clearly in your message. If you need to talk to someone right away, you can call the local police (or 911).

_____
Initials

PAYMENTS & INSURANCE REIMBURSEMENT: Psychological Testing, Assessment, Consulting Collaboration, Report Writing {if applicable} and other mandatory clerical psychological services will be provided at a rate of $_____ The date of the final report being completed is typically **within 30-business days** but may be expedited, when fees are paid in full. An expedition fee can be paid ($500.00) to receive your report quicker. Dr. Chambers can extend this agreement and report dates are merely an estimate of report production and are subject to modification. Not having all of your information and requested collateral data will delay your report and this is your responsibility. All fees must be paid to the recipient and/or his or her representatives/guardians that authorized services at the time of services up front. In no way will I attempt to circumvent this agreement through withholding finances nor will I use legal and/or other deadlines to manipulate this agreement.

_____
Initials

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide assessment services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of myself and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation

is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Santa Cruz or Santa Clara County, California, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

_____
Initials

TERMINATION: During the assessment process I will continually assess if I can be of diagnostic benefit to you. I do not assess clients who, in my opinion, I cannot assess accurately. In such a case, I will give you a number of referrals that you can contact. If at any point during the evaluation, I assess that I am not effective in helping you reach diagnostic accuracy, I am obliged to discuss it with you and, if appropriate, to terminate the evaluation and make a referral. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the assessor of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another evaluator, I will assist you in finding someone qualified, and, if I have your written consent, I will provide her or him with the essential information needed. You also have the right to terminate at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer. In the event a termination occurs, a refund may be issued after an agreed upon amount depending upon the percentage of the evaluation completed.

_____
Initials

CANCELLATION: A cancelation fee will be implemented only after 1 cancelation without calling. I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them: Dr. Chambers stores blinded or private numerical data that has no identifying information for future research purposes. Your data will be kept in accordance with state and federal law and will not ever be used in any way to identify you, but rather will be used to contribute research to the field of psychology. You may decide not to agree to this collection or request removal at any time.

_____
Initials

_____
Patient name (print) Date Signature

_____
Guardian/ representative name (print) Date Signature

_____
Clinician (print) Date Signature

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HIPPA NOTICE OF PRIVACY PRACTICES

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

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website (if applicable). You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI. I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.

If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent

threat of physical violence by you against a reasonably identifiable victim or victims. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object. 1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

B. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance. B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

D. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting

to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI. F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: 1120 McKendrie Street, San Jose, CA 95126, Phone #: 321-208-1554

VII. EFFECTIVE DATE OF THIS NOTICE This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice

Patient Name: _____Date: _____

Signature: _____

Parent/Guardian/Legal Rep.: Name:_____ Date: _____

Signature: _____

Psychologist's Name: _____ Date: _____

Signature: _____

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

This document contains important information about our decision (yours and mine) to have an in-person service in light of 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.

Decision to Meet Face-to-Face
We/Dr. Chambers/or his associates/ and I have agreed to meet in person for at least [1] testing session.

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.

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 before coming to your appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment._____
- You will wash your hands or use alcohol-based hand sanitizer. _____
- You will wear a mask in all areas of the office (I [and my staff] will too). _____
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. _____
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. _____
- 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. _____

- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know._____

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

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. 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 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.

Informed Consent
This agreement supplements the general informed consent.

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

_____ _____
Patient/Client Date

_____ _____
Psychologist Date

[Below is a sample notice to post in the office / on your website. Customize for your practice.]

Office Safety Precautions in Effect During the Pandemic

My office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- My staff and I wear masks.
- My staff maintains safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.