Saadia McLeod, Ph.D.
Licensed Clinical Psychologist
PSY17324

Consent for Purposes of Treatment, Payment & Healthcare Operations

[In this document, "I" and "my" refer to the patient or guardian]

I consent to the use or disclosure of my protected health information by Dr. Saadia McLeod for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conducting health care operations of Dr. Saadia McLeod. I understand that analysis, diagnosis or treatment of me by Dr. Saadia McLeod may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Saadia McLeod is not required to agree to the restrictions that I may request. However, if Dr. Saadia McLeod agrees to a restriction that I request, the restriction is binding on Dr. Saadia McLeod. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Saadia McLeod has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Dr. Saadia McLeod and I understand that I have a right to review Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the doctor. The Notice of Privacy Practices for Dr. Saadia McLeod is also posted in her office at 21660 Copley Drive, Ste. 210, Diamond Bar, CA 91765. This Notice of Privacy Practices also describes my rights and duties of the doctor with respect to my protected health information.

Dr. Saadia McLeod reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Dr. Saadia McLeod and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

MEETINGS

An evaluation can last from 2 to 4 sessions. If psychotherapy is begun, one 50-minute session (one appointment hour of 50 minutes duration) per week will be scheduled at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, I will be expected to pay for it unless I provide 48 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, Dr. McLeod will try to find another time to reschedule the appointment.]

PROFESSIONAL FEES

I understand that the hourly fee is $180 per therapy hour. All psychological testing will be charged at $150.00 per hour for administration, scoring/analysis and report writing. All conferences with third parties such as attorneys, judges, social workers or teachers will be charged at $150 per hour, including document reviews. All written reports for purposes of legal proceedings will be charged at $150 per hour. If I should require Dr. McLeod to serve as a witness in court proceedings per a family law case or a dependency court case, I understand that I will be required to pay for the total time spent at the court hearing at $200 per hour.

Payment is accepted for each session at the time it is held, unless we agree otherwise or unless I have insurance coverage which requires another arrangement. All co-payments are due at the end of each session.

_____ _____

Signature of Patient or Guardian Printed Name of Patient

_____ _____

Date of Signing Doctor