Rosemarie Scolaro Moser, PhD, ABN, ABPP-RP, Director
American Board of Professional Neuropsychology
American Board of Professional Psychology-Rehabilitation
NJ Psychology Lic. # SI02148
NJ Certified School Psychologist

Dear Patient,

We look forward to meeting you for your first appointment. In preparation, please **PRINT, SIGN, and RETURN** either a scanned copy or a photo of the following forms in this packet no later than 48 hours before your appointment. **Note**: we *cannot* accept printed/typed signatures. If you have any questions about how to best complete these forms, please do not hesitate to contact us by phone or e-mail.

Sincerely,

RSM Psychology Center & Sports Concussion Center of NJ Staff 5/21

281 Witherspoon Street • Suite 230 • Princeton, NJ 08540
phone 609.895.1070 or 1076 fax 609.896.2030
www.sportsconcussionNJ.com www.rsmpsychology.com

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CONFIDENTIAL
INTAKE INFORMATION

(Depending on Child or Adult, Please Complete Where Applicable) 5/21

Name_____ Date of Birth _____Today's Date_____

Gender: _____ Age _____ Social Security #: _____

Home Address _____ City/State/Zip_____

Home/Cell Phone _____Work Phone _____

Employer & Occupation-**OR**-*School & Grade & GPA*_____

Years of Education _____ Place of Birth _____ Religion, if applicable _____

Check One: Single _____; Married _____; Separated _____; Divorced _____; Widowed _____

For ADULTS: Spouse's Name, Age & Occupation_____

Children's Names & Ages_____ _____

For CHILDREN: Parents' Names & Occupations _____

Sisters'/Brothers' Names & Ages _____

Emergency Contact Name & Phone _____

Name of Primary Care Physician, Pediatrician, or Psychiatrist_____

Nature of Assistance you are seeking: (Please check)

Psychotherapy/Counseling _____	Psychological Testing _____	Neuropsychological Testing _____
Baseline Testing _____	Concussion Exam_____	Bariatric Testing_____
Spinal Cord Stim. Testing_____	Career Counseling _____	Cognitive Rehabilitation _____
Hypnosis _____	Academic Coaching_____	Biofeedback_____

Other (describe) _____

How did you hear about this service? Who referred you? _____

Describe below the difficulties or symptoms for which you are seeking assistance.

Please list any significant <u>past or present</u> medical or health related conditions, treatments, injuries or surgeries. Are you now receiving treatment for any of these conditions?

Please note if you have ever sustained a head injury, concussion, or been in a work-related, sport-related, or motor vehicle accident. Please describe and list dates.

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Have you ever been hospitalized for a medical, substance/alcohol abuse, or psychiatric problem? If yes, where and when?

Are you now receiving, or have you ever in the past received, any type of mental health or psychiatric treatment or personal or career counseling? If yes, please list diagnoses, dates, type of treatment.

Have you ever been diagnosed with a learning or attention or memory disorder? If yes, please explain.

Has anyone in your family ever received psychological/psychiatric assistance or been diagnosed with a learning or attention or memory disorder? If yes, please describe:

Please list name and dosage of any medications you are taking:

Do you use other non-prescription drugs or substances? If yes, please describe:

Do you drink alcohol? If yes, how many drinks per week?

Do you smoke? If yes, how many cigarettes per day?

Are you [*or for children*- is/are your parent(s)] a present or past military member? Yes__ No__

****

I agree to accept responsibility for all fees and payments of any services rendered to me or my child by RSM PSYCHOLOGY CENTER, LLC/SCCNJ and its providers. I understand that payment is expected at the time services are rendered. ***I also understand that I will be charged $150 for any missed appointment which I do not cancel by phone or email with at least 24 hours notice prior to my scheduled appointment.***

_____ _____

Signature Date

ONLY For: Medicare, Personal Injury, Workers Comp, TriCARE, Princeton Univ. Student Aetna

I permit RSM PSYCHOLOGY CENTER, LLC/SCCNJ to bill my Third Party Payer/Insurance company and its affiliates/contractors for services provided and to provide those entities with the necessary information to process my bills. I agree to pay all co-pays promptly and to take responsibility for payment of any services that may not be covered by my health care/insurance plan. I understand that I am responsible to know my plans' coverage prior to treatment.

_____ _____

Signature Date

Primary Insurance Carrier & Address:_____

Insurance ID/Claim # _____ Group # _____

Secondary Insurance Carrier & Address:_____

Insurance ID/Claim # _____ Group # _____

Name of Insured _____Adjuster Name & Contact Info _____

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES 5/21

As part of your evaluation/testing/treatment, we may engage in video-conferencing or other electronic communication. Please be aware of and agree to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.
- We use a secure, HIPAA compliant video platform for conferencing and strive to safeguard your privacy. However, if needed, we may communicate with you via email, FaceTime, Skype, Zoom, Google docs, telephone, or other modes, all of which may not be fully secure, private, or HIPAA Compliant.

Person/Child's Name:_____ Date_____

Signature of Person if 13 yrs or older _____

Signature of Parent/Guardian (if person is under 18 yrs.)_____

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Telehealth Call and Emergency Contact Form 5/21

Please complete all information

Date of Completion of Form:

Patient Name:

Patient Phone:

Patient Address:

Patient email address:

Place of Treatment: _____

Emergency Contact Person and Phone: _____

Local Emergency Services: _____

Please check here if patient promises that they will not record and that the session will be private and secure, unless they indicate that there is someone else in the room and that the person will be made visible to the treating doctor/staff. Yes____

Person/Child's Name: _____ **Date**_____

Signature of Person if 13 yrs or older _____

Signature of Parent/Guardian (if person is under 18 yrs.)_____

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Informed Consent for Treatment: ***After you have read the following, please sign below (for yourself, or on behalf of a minor) to indicate that you have understood and agree to the following:*** Thank you. 5/21

We are looking forward to assisting you and will make a reasonable effort to address your needs. So that you may be fully informed about our services, please read the following about our practice policies. Please do not hesitate to ask any questions if any of the following seems unclear. Also, you can find additional information about our services on our website: www.rsmpsychology.com. If at any time, you believe that your treatment is not meeting your needs, please discuss this with your doctor immediately.

If you are undergoing neuropsychological or psychological testing, please be advised that such an evaluation typically begins with an interview/exam, followed by testing, and a follow up feedback session during which results, diagnoses, and recommendations are discussed. Our office manager will be able to explain the time and costs depending on the type of evaluation you are undergoing. Please note that you will be provided with a copy of your final report. There is a charge for future copies of reports and records.

If you choose to engage in psychotherapy services, please be aware that such therapy can arouse difficult emotions and change the way you think, feel, and behave, thus affecting your relationships. Our most important mission is to help you make progress in reaching your goals. We will strive to utilize our best clinical skills and professional judgment to assist you. In the cases of minors, we ask that parents understand the need of young people to develop trust in their therapists by not requesting specific details of the treatment and respecting their child's privacy. However, we will be sure to address any important issues or concerns with parents regarding their child's treatment. Psychotherapy sessions may last 30 to 45 minutes, unless otherwise indicated. You are free to terminate therapy at any time, and we urge you to discuss your needs and concerns with your therapist so that termination may be mutually planned for. If you are involved in group therapy, we must insist that you not discuss the contents of sessions with any persons outside of the group or Center. Also, you must agree not to hold the Center or therapists liable for the actions or communications of other group therapy members.

If you are undergoing baseline testing or post-concussion screening/testing, please note that such testing involves tasks that measure brain-behavior relationships. This is not intellectual or achievement testing and alone cannot diagnose any medical or educational condition. If you are concerned that you may have a problem that should be diagnosed, then please let the doctor know, as this may require more comprehensive testing. Baseline test results will be kept on file and no formal report will be generated. These results can then be used in the future for comparison should you suffer a head injury or concussion. Also, data collected from this baseline (and any post-concussion) testing may be used for research to help further understand the nature of concussion and brain injury. All personal identifying information will be removed for research purposes. We believe that there is no risk or identified harm for such participation. If you choose not to let us use the de-identified, anonymous data for possible future research, please let us know in writing immediately.

If you choose to receive biofeedback services, please note that such treatment has been shown to be an effective tool for a number of medical conditions, but that there is no guarantee regarding how it will affect your course of recovery. If you suffer from a medical condition that requires medical clearance before participating in biofeedback, please let us know immediately.

If you choose to engage in cognitive rehabilitation services, please be advised that these services have been shown to assist in recovery from or improvement in brain disorders; however, we cannot guarantee any improvement in your condition or the extent to which you may improve.

If you choose to engage in hypnotherapy to enhance functioning or address pain, stress, or other symptoms, please be advised that such therapy is not aimed at uncovering past trauma memories, although in some cases, that may unexpectedly occur. This type of hypnotherapy is NOT intended for legal purposes.

Confidentiality: Please be aware that we will safeguard your right to confidentiality as it is protected by law. There may be situations in which your confidentiality may be limited by law, such as in certain legal and court proceedings, insurance cases, claims of disability, threats of harm to self or others, or a suspicion of abuse. If you are involved in any legal case, where your physical or mental health is at issue, please let us know immediately as our role is to provide you with treatment and **not to serve as expert witnesses, unless agreed to beforehand**. Please understand that in the role of treating provider, we will resist serving as an independent expert witness, and as such will not act to provide child custody/visitation, divorce, capacity, fitness, or injury opinions.

Payment: Payment in full is due at the time the service is rendered unless we accept your insurance plan. Our office manager can tell you which plans we accept. Co-pays and testing deposits are due at the time of service. We reserve the right to charge interest on

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accounts that are greater than 30 days overdue. **There is a returned check fee of $50. There is a $150 charge for missed appointments or those cancelled with less than 24 hour notice.** In cases in which the account has been neglected by the client/patient and there has been no show of good faith despite our repeated attempts toward resolution, we reserve the right to turn the account over to a collection service. In hardship cases, we are available to discuss payment arrangements. We are not responsible for any insurance or health care coverage. We strongly encourage you to clarify the extent of any coverage with your insurance carrier prior to your first appointment including any deductibles you may have. **Also, please note that some of the staff doctors listed below may or may not be covered by your insurance plan.** Ultimately, you are responsible for payment of the services rendered to you, whether or not they are covered by your insurance plan. Please note that Baseline Testing is generally NOT covered by insurance. Information regarding fees is available upon request and **FEES ARE POSTED IN THE WAITING ROOM TABLE BINDER**.

Mailings: At times, our office may send you invoices, receipts, general information or necessary correspondence that has our return address noted. If you prefer not to receive mailings that display our Centers' names, please let our office know in writing. Please note that we prefer not to communicate via email or text as these modes may not be HIPAA compliant.

Our doctors may be available by telephone at times other than your scheduled appointment, if there is a matter that cannot wait until your next appointment. For telephone calls that last greater than 15 minutes, we reserve the right to charge you a fee proportionate to the individual therapy rate. If you have an emergency and cannot reach your doctor, please contact your nearest hospital, emergency room or call 911.

Staff Doctors:
Rosemarie Scolaro Moser, PhD, Director (NJ Lic. SI02148; PA Lic. PS004523-L) received her doctorate in Professional Psychology from the University of Pennsylvania where she also obtained her Bachelor and Master's degrees. She is a certified diplomate of the American Board of Professional Psychology in Rehabilitation and the American Board of Professional Neuropsychology, and a certified school psychologist.

Sarah Friedman, PsyD, Post-Doctoral Fellow (NJ Lic. 6372; PA Lic. PS019153) received her doctorate in Clinical Psychology from Widener University with a specialization in Clinical Neuropsychology. She completed her Master's degree in Crisis and Trauma Studies at Tel Aviv University and her Bachelor of Arts in Psychology from the University of Pennsylvania.

Bridget Mayer, PsyD, Post-Doctoral Fellow (NJ Permit #203-036) provides patient services under her NJ Permit and the license/supervision of Dr. Moser. She received her doctorate in Clinical Psychology from Widener University with a specialization in Clinical Neuropsychology. She completed her Master's degree in Clinical Psychology with a concentration in children and adolescents, as well as her Bachelor of Arts in Psychology and Child Advocacy and Policy, from Montclair State University, where she graduated Magna Cum Laude.

Notice to Consumers: Any member of the consuming public may notify the Board of Psychological Examiners of any complaint relative to the practice conducted under the above licenses or permit at the Division of Consumer Affairs, Board of Psychological Examiners, Post Office Box 45017, 124 Halsey Street, Newark, New Jersey 07101.

_____ _____
Signature of Patient (13 years or older) Print Name of Patient

_____
Signature of Parent/Legal Guardian, if patient is a minor Print Name

_____ _____
Signature of Other Parent/Legal Guardian if required Print Name

_____
Today's Date

HIPAA: Notice of Privacy Practices

Notice of Doctor's Policies and Practices to Protect the Privacy of Your Health Information

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.
YOU WILL BE ASKED TO ACKNOWLEDGE THAT YOU HAVE RECEIVED OUR NOTICE OF PRIVACY

Uses and Disclosures for Treatment, Payment, and Health Care Operations

We (heretofore SCCNJ/RSM Psychology Center and their staff) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another doctor.

Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

Use" applies only to activities within our practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of practice group such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

- We will also obtain an authorization from you before using or disclosing: PHI in a way that is not described in this Notice. Psychotherapy notes · PHI for marketing purposes · PHI in a way that is considered a sale of PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If we have reasonable cause to believe that a child has been subject to abuse, we must report this immediately to the New Jersey Division of Youth and Family Services.

- Adult and Domestic Abuse: If we reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, we may report the information to the county adult protective services provider.

- Health Oversight: If the New Jersey State Board of Psychological Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We must inform you in advance if this is the case.

- Serious Threat to Health or Safety: If you communicate to us a threat of imminent serious physical violence against a readily identifiable victim or yourself or to the public and we believe you intend to carry out that threat, we must take steps to warn and protect. We also must take such steps if we believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps we take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising

the police of your threat and the identity of the intended victim, warning the intended victim or their parents if the intended victim is under 18, and warning your parents if you are under 18.

- Worker's Compensation: If you file a worker's compensation claim, we may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Your Rights and Doctor's/Staff Duties
Some of the following may not apply to independent evaluations to which you have voluntarily consented.
Your Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)

- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may choose to provide you with a summary of your record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

- Right to a Paper Copy: You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

- Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

- Right to Opt out of Fundraising Communications. You have a right to decide that you would not like to be included in fundraising communications that I may send out.

Psychologists' Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

- If we revise our policies and procedures, we will post such a notice in our offices and give you a copy at your next appointment.

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Dr. Rosemarie Scolaro Moser, Director, 609-896-1070 and/or the NJ State Board of Psychological Examiners in Newark, NJ, as posted in our office.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on April 14, 2003 & September 23, 2013.
We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting in our office and/or website and/or giving you a copy at your next appointment.

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Acknowledgement of HIPAA Rights 5/21

By your signature below, you indicate that you have received and/or read a copy of the **"Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information"** from RSM Psychology Center, LLC/SCCNJ. The notice is available on websites: www.sccnj.com and www.rsmpsychology.com as well as in the offices of RSM Psychology Center and SCCNJ.

_____ _____
Signature of Patient (13 years or older) Date

_____ _____
Print Patient Name Birthdate

_____
Signature of Parent/Guardian if patient is under 18 years

_____
Signature of other Parent/Guardian if required

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Notice to Patients ----January 25, 2021 5/21

During this COVID-19 pandemic, we are very concerned about the welfare and health of our patients and staff. We are committed to making our office a very low risk environment, and although there are no guarantees regarding safety during the course of this pandemic, we will adhere to a set of standards for everyone's safety. Our staff is vigilant in sanitizing areas and surfaces of the office suite that are in common tactile contact, and prioritizes frequent hand washing and hand sanitizing.

To minimize exposure for all in the office, it is your responsibility to understand and abide by the following:

1. You will only keep your in-person appointment if you are symptom free.
2. You will take your (and your child's if applicable) temperature before coming to each appointment. If it is elevated (99.4 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth if appropriate. If you wish to cancel for this reason, we will not charge you our normal cancellation fee.
3. You will wash your hands or use hand sanitizer upon entering the office waiting room.
4. You will try not to touch your face, eyes or mask with your hands. If you do, you will immediately wash or sanitize your hands.
5. You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.
6. You will wear a mask in all areas of the office and our staff will too.
7. You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with staff. During testing, some tests may require closer contact and the doctor will advise you of safety precautions.
8. If you have more than one in-person visit, you will take steps between visits to minimize your exposure.
9. If you have a job that exposes you to those who are infected, you will let us know.
10. If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let us know.
11. For your safety, our waiting room will only accommodate one party at a time. You should come alone or be dropped off for your appointment. In the case of a child, disabled individual, or other individual requiring a companion, exceptions will be made at the discretion of the doctor.
12. You will wait in your car or outside until no earlier than 5 minutes before our appointment time.
13. If you display any symptoms, fever, or suspicion of a cold or flu-like symptoms you will not be seen for evaluation, treatment, or testing. If you are observed with such symptoms in the waiting room, you will not be permitted to enter the office suite.
14. If a resident of your home tests positive for the infection, you will immediately let us know and we will then consider services via telehealth, if appropriate.
15. If you have had contact with a suspected or confirmed COVID-19 case, you will not be scheduled for in-office treatment or evaluation until cleared by medical, physician note, or two weeks have elapsed since such contact, during which time you have been symptom free.
16. If you have traveled beyond the continental US, or by mass public transport, such as bus, train, ship, or airplane within the last two weeks, or been in a rally, parade, or similar large gathering, your appointment will be scheduled a) no sooner than two weeks after such event, during which time you have been symptom free, or b) cleared by physician note that you are not infected with COVID-19.

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17. If you are undergoing psychological, neuropsychological, or concussion testing: a) the tester will wear gloves (as feasible) and a mask; b) you will be asked to sanitize your hands upon entering the office and as needed; c) the tester will maintain social distance as feasible and appropriate and will use a clear divider between the tester and you during manipulation of test materials, d) the tester will sanitize the testing area and materials as needed; e) you will be asked to wear a mask and gloves (if feasible) during testing; f) if you cough, or display any suspicious symptoms, the tester may ask you to discontinue testing for another time, at the tester's discretion.
18. For testing cases, we may ask you to complete some of the testing by videoconferencing, as advised by the doctor, to reduce time in the office. Please understand that if you undergo remote or video testing, the remote technology and platform may affect the reliability or validity of some of the tests that have been created for in person use. Your doctor will be cautious when interpreting those tests.
19. For non-testing appointments, you are asked to meet virtually with the doctor or staff. This includes therapy, exams, feedback sessions, and consultation. Our office staff can assist with setting up electronic or telephonic communication. For patients choosing virtual treatment, they will need to complete consent forms for using electronic/telephonic communication, and consent forms for certain types of connections that may not be guaranteed secure per HIPAA guidelines. We strongly recommend virtual sessions for our most vulnerable older individuals and those with underlying physical conditions.
20. All payments for services should be discussed prior to the appointment with our office manager, who will arrange for such payment in advance of your appointment. To reduce exposure risk and to maintain social distancing, patients may: 1) pay by credit card over the phone or complete a credit card authorization form that can be emailed to our office, which can be used for payment, or 2) provide a check in an envelope which can be mailed or left at the front waiting room for the Office Manager.
21. If you are bringing your child for testing, you will make sure that your child follows all of these sanitation and distancing protocols.
22. You have the option to postpone testing, should the above make you feel uncomfortable, however you should understand that the current health environment is indefinite, and we are unsure of the timeline of this pandemic or how it will change.
23. Please direct your questions to our office manager, 609 895 1070 or manager@rsmpsychology.com.

Decision to Meet Face to Face

If we've agreed to meet in person for testing or therapy sessions, you understand that by coming to the office, you are assuming a 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. We 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. Please know that this policy may change quickly depending on medical and governmental updates.

Please sign below indicating your understanding of, and agreement with, the above and that you voluntarily choose to engage in an in-person, in-office service, and understand the risks:

Signature of Patient if 13 years or older	Print Name	Date
Signature of Parent/Guardian if patient is under 13 years of age.	Print Name	Date

Rosemarie Scolaro Moser, PhD, ABN, ABPP-RP, Director
American Board of Professional Neuropsychology
American Board of Professional Psychology-Rehabilitation
NJ Psychology Lic. # SI02148
NJ Certified School Psychologist

CONSENT FOR DISCLOSURE OF CLIENT/PATIENT RECORDS OR COMMUNICATION 5/21

I hereby authorize **RSM Psychology Staff** to disclose information and/or receive information to the extent or nature indicated to/from **Recipient Name/ Address**: _____ for the purpose of **case consultation and/or billing**.

The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose and may include the following items **(unless crossed out by me)**

Drug and/or alcohol abuse information
Information regarding Immunodeficiency virus (HIV) including laboratory test results
Diagnosis of AIDS or ARC, if applicable
History and physical examinations
Psychological & neuropsychological test results
Raw data from psychological and neuropsychological tests
Clinical notes, including correspondence and billing/insurance information
Psychological and neuropsychological reports
Other: _____

regarding: **(Patient Name)**_____

whose date of birth is _____ and whose social security number is _____.

I understand that in New Jersey the communications between patients and psychologists are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately and will expire after **365** days from the date of signature. However I also understand that I may revoke my consent before **365** days elapses by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connection with the aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is released, there is potential for that information to be redisclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original.

I hereby release **RSM Psychology Center** and its employees, personnel, officers, directors, and professional health care providers from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Signed:_____
Client/Patient (13 years or older)
Signed:_____
Parent, Legal Guardian if Patient is under 18 years of age
Signed:_____
Other Parent/Legal Guardian
Date: _____