Dr. Linda Caterino, Ph.D., A.B.P.P.
Licensed Psychologist

Informed Consent

Patient

Full Name: _____ Patient Birthdate: _____
Last *First* *M.I.*

Limitations of Services

I understand that Dr. Caterino's services are limited to psychological evaluation, assessment, consultation, therapy, and intervention. I understand that evaluation and assessment services may also include the use of psychological and neuropsychological tests. I understand that intervention services may include counseling and brief psychotherapy. I understand that Dr. Caterino is not warranting a cure or offering any guarantee of results or improvement of any condition.

Patient or Minor Parent/Guardian: Please Initial to Indicate that You Understand and Agree to this Section: _____

Assumption of Risks and Benefits

Potential benefits of treatment include clarifying diagnosis and or reducing emotional, behavioral, or relationship problems. I understand that potential risks may include limited predictive validity of psychological assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures include services provided by another psychologist, psychiatrist, or mental health professional, or no treatment.

Patient or Minor Parent/Guardian: Please Initial to Indicate that You Understand and Agree to this Section: _____

Limits of Confidentiality

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below. I understand that confidential and privileged information may be released without my consent or authorization in the following circumstances recognized by Arizona law and HIPAA:

Child Abuse: If Dr. Caterino knows, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that Dr. Caterino report such knowledge or suspicion to the Arizona Child Protective Services.

Adult and Domestic Abuse: If Dr. Caterino knows, or has reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, Dr. Caterino is required by law to immediately report such knowledge or suspicion to the Abuse Hotline.

Health Oversight: If a complaint is filed with the Arizona Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If the patient or parents are involved in a court proceeding and a request is made for information about the patient's diagnosis or treatment and the records thereof, such information is privileged under state law, and Dr. Caterino will not release information without written authorization and a subpoena.

Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, Dr. Caterino may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Worker's Compensation: If you file a worker's compensation claim, Dr. Caterino must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

Patient or Minor Parent/Guardian: Please Initial to Indicate You Understand Agree to this Section: _____

Subpoenas and/or Court Involvement

I understand that I will not involve or engage Dr. Linda Caterino in any legal issues or litigation in which I or my child is a party to at any time either during my therapy or evaluation, or after my therapy or evaluation terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, Best Interests Attorneys, psychological evaluators, alcohol and drug evaluations, or any other contact with the legal system.

I understand that Dr. Caterino may not respond to any records request, speak to attorneys/judges, or testify at any deposition, hearing or other legal proceeding unless she is duly and timely served with a subpoena or a court order which fully complies with Arizona law.

In the event Dr. Caterino is required to respond to a subpoena or court order requiring the release of records or is required to appear at a hearing or deposition, or otherwise engage in a legal proceeding or with attorneys/evaluators, I understand and agree that the requesting party is responsible for and shall pay Dr. Caterino's expert witness fees including travel time, preparation, permissible copy/research charges, and the like at least 15 calendar days in advance. Those fees will be disclosed at the time as they are subject to change.

Patient or Minor Parent/Guardian: Please Initial to Indicate that You Understand and Agree to this Section: _____

Release of Information

I understand that my records may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, I understand that I am waiving the confidential nature of the patient-psychologist relationship.

I authorize the release of information as necessary for the purpose of Dr. Caterino obtaining consultation regarding my evaluation or treatment.

If I am a hospitalized inpatient, I understand and agree that Dr. Caterino may discuss my evaluation and treatment with my physician, hospital staff, utilization review staff, and others concerned with my care.

I authorize the release of any and all information requested by my managed care company or insurance carrier for the purpose of processing my insurance claim and obtaining payment for services. If I am entitled to Medicare or managed care benefits, I authorize the release of information to Medicare or to my managed care company.

By authorizing the release of information to an insurance company or other third party, I understand that the information may become part of the third party's records and that Dr. Caterino can no longer control any subsequent release of that information. Dr. Caterino has informed me that should I ever authorize a general release of my medical records from an insurance company or other third party, it is possible that the third party's copy of my psychological records could possibly be released by the third party without Dr. Caterino knowledge.

I understand that Dr. Caterino cannot prevent any hospital, physician's office, or insurance company from releasing or redisclosing information to the Medical Information Bureau or other agencies or persons. I hold Dr. Caterino harmless for any secondary release or redisclosure of my report made by the hospital, the physician's office, the insurance company, the medical information bureau, or any person or agency to whom the report is originally released.

After giving consideration to the extent of this release, I specifically direct and authorize Dr. Caterino to exchange confidential information and discuss his opinions with the following agencies (for example, referring physician, insurer, family member) named below for the purpose of providing information about my evaluation or treatment:

_____

If I am entitled to Medicare Benefits, I authorize Dr. Caterino to discuss my case with my primary care physician or the physician who referred me. I understand that this is a requirement for Medicare reimbursement.

Patient or Minor Parent/Guardian: Please Initial to Indicate that You Understand and Agree to this Section: _____

Release of Information

By signing this form, I expressly indicate that I understand and agree with the terms and conditions of this form and am not under any coercion to sign this form. I further certify that I have read and understand this form, or that it has been read and explained to me in terms that I understand. My questions have been answered to my satisfaction, all blank spaces on the form have been completed, and all statements of which I do not approve have been stricken. I acknowledge that I voluntarily consent to the preceding conditions and that this consent form is valid during any related claims. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I specifically hold Dr. Caterino harmless for releasing information under any of the above conditions.

If signed electronically, I agree my electronic signature has the same validity and meaning as my handwritten signature.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____