Real Hope Real Help
1001 Cross Timbers Road, Ste. 1240
Flower Mound, TX 75028
Ph: (972) 966-1079 F: (972) 767-0755
Realhoperealhelpdr.d@outlook.com

Patient Intake Form

Patient Name (Last, First, Middle): _____

Date of Birth: _____ Gender: _____ Family Status: _____

Address: _____

Primary Phone #: _____ Secondary Phone #: _____

E-Mail Address: _____ Preferred Method of Contact: _____

Please fill out either the adult patient or minor patient information section, then complete the additional information section.

ADULT PATIENT INFORMATION:

Occupation: _____ Employer: _____

Employer Address: _____

CONSENT FOR TREATMENT: I hereby give my authorization and informed consent to receive psychological or therapeutic outpatient diagnostic and treatment services from REAL HOPE REAL HELP. I further certify that I have the legal authority to authorize and consent to this treatment.

_____

PRINT NAME SIGNATURE TODAY'S DATE

MINOR PATIENT INFORMATION:

Parent/Guardian's Name: _____ Date of Birth: _____

Gender: _____ Relationship to Patient: _____ Marital Status: _____

Home Address: _____

Employer: _____ Address: _____

Other Parent/Guardian's Name: _____ Date of Birth: _____

Gender: _____ Relationship to Patient: _____ Marital Status: _____

Home Address: _____

Employer: Address:

CONSENT FOR TREATMENT OF MINOR/DEPENDENT CHILD: I certify that I am the (father, mother, managing conservator, legal guardian (circle one) of the above named child, and I hereby give my authorization and informed consent for the above named child to receive psychological or therapeutic outpatient diagnostic and treatment services from REAL HOPE REAL HELP. I further certify that I have the legal authority to authorize and consent to this treatment.

Print Name Parent/Legal Guardian Signature Today's Date

ADDITIONAL INFORMATION:

If insurance Holder or Financially Responsible Party is same as previous contact listed, you only need to fill in the name.

Insurance Carrier: Primary Subscriber's Name:

Date of Birth: Gender: Phone Number:

Primary Subscriber's Address:

Employer: Employer's Address:

Financially Responsible Party's Name: Date of Birth:

Gender: Relationship to Patient: Marital Status:

Home Address:

Employer: Employer's Address:

CONSENT FOR ALTERNATE CAREGIVER/EMERGENCY CONTACT (optional): If you consent to allow REAL HOPE REAL HELP to discuss your protected health information with anyone other than yourself or the parent/legal guardian for minor patients, please list them below. Your signature will indicate your consent to this communication until you withdraw your consent in writing.

Emergency Contact Name: Phone #:

Print Name Signature Today's Date

CONSENT TO COMMUNICATE WITH REFERRAL SOURCE: If you consent to allow REAL HOPE REAL HELP to communicate with your referring physician or professional regarding your case, please sign below. Your signature will indicate your consent to this communication until you withdraw your consent in writing.

Physician/Professional Name: _____ Phone #: _____

Print Name: _____ Signature: _____ Date: _____

IN-NETWORK INSURED: If you wish for REAL HOPE REAL HELP to file for direct in-network reimbursement by your insurance company, please provide the information requested below.

I hereby assign payment of medical benefits by: (Insurance Company): _____
To REAL HOPE REAL HELP. I also authorize the release of any medical information requested by the above-named insurance or managed health care company. The assignment will remain in effect until revoked by me in writing (a photocopy of this assignment is to be considered as valid as the original(. I understand that I am financially responsible for all charges whether or not paid by said insurance except to the extent that a contract between the provider and a managed health care company might limit that financial responsibility.

Print Name: _____ Signature: _____ Date: _____

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Adult Patient Information

Patient Name: _____ Date: _____

1. Please describe the problem for which you are seeking help in the space below.

2. How would you describe the severity of the effects of the problem on you? Circle one.

   A Little Bit Moderately Quite Extremely

3. Please describe any prior counseling, therapy, or evaluation services received, including dates of services.

4. Please list any medications you presently take, and the dosage prescribed. Also, list any nonprescription medicine regularly taken.

5. Please describe any medical conditions for which you are being treated.

6. Please identify which of the following you use and the frequency and quantity.

	Circle one	Frequency	Quantity
Alcohol	Yes / No		
Caffeine	Yes / No		
Drugs	Yes / No		
Nicotine	Yes / No		

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HIPAA Policies & Agreement for Psychological Services and Applied Behavior Analysis

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. Please read it carefully. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless I have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Confidentiality and Consent

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I will obtain a written consent. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is referred to as "PHI" in this document).
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient. There are some situations where I am permitted or required to disclose information without either your consent or Authorization:
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the

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law requires that I make a report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such report is filed, I may be required to provide additional information.

- If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in a professional record. I have transitioned to electronic records and administration processes using the professional tool, www.Therapyappointment.com. This includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record. . If you desire a copy of your/your child's record, I will be happy to discuss it with you or provide a treatment summary. There will be a charge for records requests, unless another professional requests the records. Records can take up to 15 business days to be processed and require you to complete a written Authorization to Release Records. If you/ your child are psychologically evaluated (tested), you will receive one copy of the evaluation without charge. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Requests for raw data will only be released to another mental health professional.
I work with many physicians in this area and am happy to discuss treatment plans and updates; however I will need a written Authorization to Release Records prior to consultation.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

Minors & Parents

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children between 16 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I may request an agreement from the patient and his/her parents that the parents' consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the

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parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Psychological Services

I provide a variety of psychological services including individual, family and group psychotherapy, psychological & neuropsychological testing and also applied behavior analysis. Psychotherapy helps a variety of emotional and interpersonal problems. It intends to reduce or eliminate certain psychological symptoms, and to improve social, academic or interpersonal functioning. Applied behavior analysis aims to improve behavior in socially significant ways.

Psychotherapy can have risks and benefits. Since therapy sometimes involves discussing unpleasant aspects of life, you or your child may experience uncomfortable feelings. On the other hand, psychotherapy had also been shown to lead to benefits such as better relationships, solutions to specific problems and significant reductions in feelings of distress. There are no guarantees of what you will experience.

In the first session or two, I will evaluate your/ your child's needs. By the end of that time, I will offer you some first impressions of what our work will include and a treatment plan to follow. If you have any questions about my procedures, we should discuss them whenever they arise.

Meetings

After the initial assessment, we will discuss your/ your child's treatment plan. When follow up sessions begin, sessions last 45-50 minutes in duration. Occasionally, shorter sessions are held, and will be billed at a lesser rate. Sessions may be held weekly or less often, depending upon your child's needs.

Contacting Me

I am in the office daily during the week, but I am not available to answer the phone when I am with a patient. When I am unavailable, you may leave a voicemail for non-emergency situations at (972) 966-1079. I will make every effort to return your call on the same day you make it. If an urgent situation arises after office hours, I am available by calling, and possibly leaving a message at, (469) 993-9167. However, if an emergency exists and you cannot wait for a return call, go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. Please be aware that I strive to conduct clinical conversations only within sessions, not over the telephone or email.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Patient's Name Patient/Parent or Guardian Signature

_____

Date

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Billing & Financial Policies

Real Hope Real Help provides the following policies with the intent to build a clear and trusting relationship with the patient and their families. It is the hope that these policies will assist in avoiding misunderstandings concerning payment for professional services and provide the highest quality of care.

Please initial next to each policy listed below:

_____ PROFESSIONAL FEES: My hourly rate for an initial appointment is $183.00 and follow-up appointments are $180.00 for 60 minutes and $150.00 for 45 minutes. Other services are telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing other services you may request. If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for the clinician's professional time, even if your clinician is called to testify by another party. Because of the difficulty of legal involvement, there is a $400.00 per hour fee for preparation and attendance at any legal proceeding. If you are insured through a deductible plan and your deductible has **not been met**, the office will collect the fee insurance companies allow. Deductible fees, Co-insurance and Co-payment amounts are due at the time of service. If services are requested that are not covered by insurance, it will be the responsibility of the patient/parent to pay for these services. Educational Advocacy is $180.00 per hour.

_____ PSYCHOLOGICAL TESTING: There are two options for testing, Insurance and Private Pay. Insurance companies only pay for medically necessary testing. Insurance companies will not pay for Educational testing. Private Pay testing is charged according to the type of testing, and you will be given a good faith estimate based on $150.00/hour for testing time, or educational testing. Additionally, you will incur a Protocol Fee based on the number of tests administered. You will be given a written notice of the protocol fee prior to testing, which is due by the day of testing. Any misplaced test which have to be reissued and/or not returned on the day of testing or prior to testing will incur additional fees. Missed appointments, without 24-hour prior cancellation notice, will assess a "no-show/late cancellation" fee of $100.00. One copy of testing results will be provided free of charge; additional copies will incur a $50.00 fee.

_____ NONCOVERED SERVICES: If your insurance company does not pay for services rendered, those balances will become the patient's/parent's responsibility. Insurance filing is processed by software provided by Therasoft. Before receiving services, you must verify that your clinician is a participating provider for your insurance company. You can do this by calling the number on the back of your insurance card and having them verify that your clinician is in-network with your specific policy. Should it come back that the services are not in-network, you will be financially responsible for the out-of-network services rendered.

_____ INSURANCE CHANGES: It is your responsibility to provide the office with any and all changes to your insurance, billing address, and contact information. If new insurance information or any changes are not received within 3 business days of your visit, you will be financially responsible for services rendered.

_____ PAYMENT/CHILDREN OF DIVORCED PARENTS: Co-payments, co-insurance, deductibles, and self-pay balances are due at the time services are rendered. Claims will be files to your primary insurance.

_____ INSUFFICIENT FUNDS: An account paid by check which is returned by the bank unpaid for any reason will be charged $60 in addition to the original balance. The office may also seek additional legal remedies under Texas law. Payment must be made by cashier's check, cash, or credit card.

_____ PRIMARY INSURANCE: We will file claims with your primary insurance companies which we are contracted. We do not file claims to secondary policies.

_____ STATEMENTS: We will send a statement (to the billing address you provide). Payment is due upon receipt of the statement. If you have any questions or dispute the validity of the balance, it is your responsibility to contact the Billing Department. Accounts not paid within 30 days of the statement date are considered past due. If you have difficulty paying your bill, payment arrangements may be made; however, it is your responsibility to contact the Billing Department and discuss a payment plan within 30 days to keep your account from being past due. If your account is over 60 days past due and you have not made payment arrangements, your outstanding balance will be sent to a collection agency.

_____ MISSED APPOINTMENTS/LATE CANCELATIONS WORK-IN APPOINTMENTS: In order to meet treatment goals, it is essential that the patient arrive to the office 10 minutes prior to every scheduled appointment. Additionally, there are patients waiting to be scheduled for an appointment and when you fail to show up for your appointment or do not cancel 24-hours in advance, this slot cannot be filled with another patient needing services. Missed appointments, without 24-hour prior cancellation notice, will assess a "no call, no show/late cancellation" fee of $85.00. Patients arriving more than 20 minutes late to their appointment will be required to reschedule and will also incur a "no show/late cancellation" fee. If there are 3 or more no shows or late cancellations, you must call the Office Manager to discuss the matter before another appointment may be scheduled. Work-In appointments for emergencies or other special circumstances will be available but must be discussed prior to the appointment. The same "no call, no show/late cancellation" rules will apply to these appointments. We will allow one (1) no call, no show/late cancellation without charge, but after that <u>any</u> reason an appointment is missed without 24-hour notice will be a fee of $85.00. If a testing appointment is missed or not cancelled within the 24-hours a fee will be received for this service in your name.

_____ MEDICAL RECORDS/ FORMS & LETTERS: You must complete and sign an Authorization to Release Information/Records. There will be a $25 fee for records requests unless another professional request the records. Most Forms and Letters will incur a $50 fee. Please allow 2-3 business days for all forms and letters to be processed. Disability paperwork will range from $75.-$150. Depending on length and complexity of the form.

Your signature below indicates you have read and agree to abide by the Billing and Financial policy during the course of our professional relationship.

_____ _____

Patient's Name Patient/Parent or Guardian Signature

_____

Date

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Appointments and Cancellation Policy

In order for us to be available to you in a predictable manner, our services are provided on an appointment basis. We schedule our own appointments, and if and when necessary, we will give you personal notice should your scheduled time with us need to be changed. If you find that you will be unable to keep an appointment, we request that you give us at least 24-hour notice. The charge for appointments cancelled with out a 24-hour notice will be $85. This charge will be waived only in the case of an emergency.

No Show/Missed Appointment Policy

We, at Real Hope Real Help understand that sometimes you need to cancel or reschedule your appointment and there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling our office at (972) 966-1079. You may also leave a voice message at our office phone number with at least a 24-hour notice.
It is the patient's responsibility to arrive on time to their scheduled appointment. To ensure that each patient is given their allotted appointment time and high-quality care is given, it is important for each scheduled patient to arrive to each visit on time. An appointment reminder call we be attempted one (1) business day prior to your scheduled appointment.

Emergencies

Since we provided services on an appointment only basis, should you have an issue that **cannot wait until our next available appointment**, please leave us a voice message at (972) 966-1079 and we will attempt to return your call in the same day. If you have a **life-threatening emergency**, please go to the nearest emergency room, or call 911.

Please Review the Following Policy:

1. Your appointment must be cancelled with at least 24-hour notice.
2. If less than a 24-hour cancellation is given, it will be labeled as a "No Show"
3. If you do not present to the office for your appointment will be marked as a "No Show"
4. After the first "No Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No Show" policy.
5. If you have two (2) "No Show/Missed" appointments within one calendar year, you will receive a warning phone call or letter and will be assessed a $85 no show fee that will be withdrawn from your credit card on file.
6. If you have three (3) "No Show/Missed" appointments within one calendar year, you will receive a second $85 no show fee.

I have read and understand Real Hope Real Help's No Show/Missed Appointment Policy and understand that it is my responsibility to plan appointments accordingly and notify Real Hope Real Help appropriately if I have difficulty keeping my scheduled appointments.

Signature: _____ Todays Date: _____

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Credit Card Guarantee of Payment

I understand that Real Hope Real Help will be billing me for therapy, evaluations, or psychological testing services. With this form, I give Real Hope Real Help permission to charge my credit card for any services that have not been paid by me within 24 hours of a missed therapy appointment or late cancellation, or with in 60 days of billing. If services have not been paid with in 30 days, Real Hope Real Help will notify me in writing of the outstanding payments.

I understand that Real Hope Real Help uses the credit card processing company Emdeon. On my credit card statement the charge will appear as it is coming from that company and not from Real Hope Real Help.

I understand that I must complete this form/agreement to be seen as a patient **in this practice.**

Patient Name: _____

Cardholder Name: _____

Cardholder Billing Address: _____

_____

Type of Card (Circle One): Amex Discover Master Visa

Credit Card Number: _____

Security Code: _____ Expiration Date: _____/_____

Signature: _____ Date: _____

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Consent for Electronic Communication

Unencrypted email is not a secure form of communication. There is some risk that an individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive emails from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

My email address is: _____@_____

Please check all that apply:

☐ I consent and accept the risk in receiving information via email/text message. I understand I can withdraw my consent at any time.

☐ I **DO NOT** consent to receiving any information via email/text. I understand that I can change my mind and provide consent later.

☐ I consent to receiving information about office announcements via email/text.

_____ _____

Patient's Name Patient/Parent or Guardian Signature

_____

Date

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_____
Client Name

CONSENT TO PARTICIPATE IN A TELEHEALTH CONSULTATION/TREATMENT

DEFINITION: Per the Texas Occupations Code, Chapter 111, **Telehealth service** means a "health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology."

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

In order for the telehealth service to take place, please go through and understand each item in this informed consent form. If you have questions, please do not hesitate to let us know and we will be more than happy to answer them for you.

1. I understand that I/my child am voluntarily participating in a treatment using telehealth technology rather than an in person, face to face, visit.
2. I understand that this consultation/treatment will not be the same as an in-person, face-to face, patient/health care provider visit due to the fact that I/my child will not be in the same room as my health care provider. My health care provider has explained to me how the video conferencing technology will be used in connection with this consultation/treatment.
3. I understand that I/my child may benefit from telehealth, but results cannot be guaranteed or assured. The benefits of telemedicine may include but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.
4. The technology used by Real Hope Real Help, Microsoft Teams, is encrypted to prevent unauthorized access. Despite Real Hope Real Help's best efforts to protect the privacy of such information, security protocols could fail, causing a breach of privacy of confidential and Protected Health Information. Thus, I understand there are potential risks when using this technology, including interruptions, possible unauthorized access of medical information, and technical problems, e.g., equipment failure.
5. I understand that I have the right to withhold or withdraw consent to telehealth treatment at any time without affecting my/my child's right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I/my child would otherwise be entitled.
6. I understand that the laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me/my child

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during the course of my/my child's treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse or neglect; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

7. I understand that this document will become a part of my/my child's medical record.
8. I understand that I have the right to access my/my child's medical information and copies of medical records in accordance with Texas state law.
9. I understand that if I or my child need emergency mental health services, I should contact my local emergency room and/or call 911.
10. Video recordings may be taken of the telehealth treatment, only when video recording is already a part of standard clinical practices.
11. I understand that billing will be performed by Real Hope Real Help.
12. I have read this document carefully, and understand the risks and benefits of the telehealth treatment and have had my questions regarding the technology answered. I hereby consent to participate in telehealth treatment under the terms described herein.

_____ _____

Client/Parent/Guardian Printed Name Client/Parent/Guardian Signature

_____

Date

Christina Della Nebbia, Ph.D., Inc.
1001 Cross Timbers Road, Ste. 1240
Flower Mound, TX 75028
Ph: (972) 966-1079 F: (972) 767-0755
Patient@realhoperealhelp.net

Real Hope Real Help
ABA, Counseling & Testing Center

Consent to Perform Services
Delegation of Services

Welcome to Real Hope Real Help ABA, Counseling and Testing Center. This form will provide information about our office and our services. Please be sure to discuss any questions or concerns with your clinician, Dr. Christina Della Nebbia, Ph.D.

All services are provided directly by the clinician's stated above, or they could be delegated to a clinician under the supervision of Dr. Christina Della Nebbia. Clinicians that are under supervision are doctoral level trainees such as post-doctoral fellows, doctoral level practicum students, pre-doctoral level interns, and licensed psychological associates. All clinicians under supervision have at least 5-10 years of training and supervised experience. They are closely supervised and delegation of services such as completing psychological testing and/or counseling are done under the license of Christina Della Nebbia, Ph.D. The licensed psychologist is responsible for the initial evaluation (interview/intake), ongoing care and development of the treatment plan. The psychological report is the responsibility of the licensed psychologist and counseling cases are reviewed on a weekly basis with all trainees. All clinicians on staff have received an extensive screening process prior to hiring to assure a high level of clinical expertise and competency. They also receive in-depth supervision and ongoing training.

By signing this form, I agree to allow a psychology professional in training to complete services under the supervision of a licensed psychologist. If any concerns arise, please address your concern to the supervising psychologist.

Clinicians on staff:

- Chris Carter
- Jason Smith
- Cintia Martinez

Patient or Parent Name:_____

Signature:_____

Date: _____