Watson
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Dear Parent/Guardian:

Thank you for your interest in the services provided through The Watson Institute Psychological Services Department.

Prior to your child's initial appointment, please read and complete/send the following:

- Completed Intake packet, which was either sent to you via DocuSign, email, or mail.
- Legible copy of both front and back of all insurance cards for verification of benefits. Please enlarge the copies if possible.
- Information can be sent in the following manner:

  Email to: intake@thewatsoninstitute.org
  Fax to: 412-741-9021
  Mail to: The Watson Institute, 301 Camp Meeting Road Sewickley, PA 15143

Additionally, for psychological/neuropsychological testing, please bring with you or send in any copies of previous testing, whether completed by School District or another Provider. Evaluation reports or Reevaluation Reports from the school district should also be provided. Copies of Individualized Education Plans (IEP) are not required.

Should you have questions regarding the contents of this packet, please feel free to contact our office at: 412-749-6425 or intake@thewatsoninstitute.org.

The Watson Institute
Insurance Authorization and Billing Information

This document provides an explanation of the insurance and payment process for services provided through the Psychological Services Department at The Watson Institute.

We participate with **most** Blue Cross, UPMC Health Plan, and Pennsylvania Medical Assistance in most counties.

We will call every insurance company to verify benefits and obtain an authorization on your behalf for both participating and non-participating insurance companies.

Your insurance company may or may not give us authorization for you to receive services from The Watson Institute. If they give us permission for you to receive services, we will bill your insurance company on your behalf. In some instances, they may send payment to you directly and we will then bill you for the services. You will be responsible for forwarding whatever payment you receive from your insurance company and also be responsible for all deductibles, co-insurance, co-pays, or non-covered charges. Most likely, if your child has Medical Assistance, these charges **can** be covered.

Please note that if the primary insurance company denies payment either because of not having out-of-network benefits or not having an authorization in place, Medical Assistance will not cover these services either. Medical Assistance is always the payor of last resort and primary commercial insurance needs to be billed first.

Authorization is not a guarantee of payment. We will process all claims to the insurance company(s); however, ultimately any unpaid balance will be your responsibility.

It is important to present the correct insurance card(s) for **every** insurance that you carry for your child, on every date of service. **If your insurance changes or Medical Assistance is added during the process of the evaluation or treatment of your child, please let The Watson Institute know immediately.**

If you do not present every insurance card(s) for every visit, you may receive a bill for the service.

The Watson Institute
Outpatient and IBHS Services Contract

This document contains important information about business policies and services provided through The Watson Institute. Please read it carefully and ask any questions necessary to understand the document. When you sign this document, it will represent an agreement between you and The Watson Institute.

Consent for Psychological Services and Treatment:
I hereby consent for my child to receive an evaluation, psychological/neuropsychological testing, medication management, Intensive Behavioral Health Services (IBHS), and/or therapeutic services from The Watson Institute.

For psychological/neuropsychological testing, I understand that seeking an assessment does not guarantee that The Watson Institute will be able to conclude that my child has the diagnosis I am seeking testing for or that the testing outcomes will result in accommodations or services I am seeking. The psychological testing process will usually occur in three sessions. The first session, which lasts for approximately one hour, consists of a face-to-face interview with me and my child in order to determine the reason for the evaluation, to obtain history and presenting concerns, and to determine if psychological/ neuropsychological testing is necessary. The second session, which occurs in person and lasts for approximately three hours, consists of a test battery selected by the evaluator and administered to my child in order to answer the referral question. I will also be required to complete questionnaires during this session. Finally, a feedback session is scheduled sometime after the testing session in order to discuss the results of the evaluation and recommendations. The feedback session lasts for up to one hour. Following the completion of the feedback session, the testing report will be finalized and mailed out to me no more than three weeks after the feedback session.

For therapeutic services, including IBHS, outpatient individual and group therapy, and medication management, I understand that the nature and goals of my child's treatment will be agreed upon by me and my child's treatment team, and will be documented in a treatment plan that I will be asked to sign. I am aware that the practice of behavioral and psychological intervention and evaluation is not an exact science and I acknowledge that there are no guarantees as to the outcome of any treatments or evaluations that my child will receive.

I understand that the benefits and risks of any of the services provided can be discussed with my child's clinician.

I understand that in order to authorize mental health treatment for my child, I must have either sole or joint legal custody of my child or I must be the child's legal guardian with supportive documentation. If I am separated or divorced from the other parent of my child, The Watson Institute should be notified immediately. I will be asked to provide a copy of the most recent custody decree that establishes custody rights of me and the other parent or otherwise demonstrate that I have the right to authorize treatment for my child. If the other parent shares medical rights based on the custody agreement, I understand that the other parent will also have to provide consent in order for me to schedule my child an appointment at The Watson Institute.

I also understand that I have a right to withdraw my consent for services at any time.

I understand that it is important that I mention promptly to my child's therapist, psychologist, or psychiatrist any concerns or questions that I may have at any time during the process of treatment.

Confidentiality & Release of Information:
I understand that all communications with a clinician and all records relating to the provisions of psychological services are confidential and may not be disclosed without my written consent or the written consent of my child

(age 14 and over) except in those circumstances required by law, such as in instances of reported child or elder abuse or neglect as well as when patients are at imminent risk of committing suicide or homicide.

Most assessments, such as those that occur at the start of therapeutic services or when psychological/neuropsychological testing occurs, require a significant amount of information from the client. Frequently, The Watson Institute will request that I obtain records and any other relevant documentation and provide those records to the clinician. The Watson Institute may also request that I sign release forms on a yearly basis so that information from other relevant individuals, such as parents, caretakers, school officials, teachers, and physicians or other treatment providers, can be obtained. I understand that The Watson Institute will obtain my authorization, on an annual basis, for the release of any records. I am able to withdraw these releases of information at any time. Those who can access the records without specific approval include The Watson Institute employees and contracted employees in the course of their jobs.

Professional Records:
I understand that, pursuant to HIPAA, The Watson Institute keeps Protected Health Information (PHI) about my child in my child's secure Electronic Health Record. It includes assessments, treatment notes, any past treatment records, releases, consents, and billing records. Except in unusual circumstances that involve danger to me or my child, I may examine and/or receive a copy of my child's Electronic Health Record if I request it in writing. In most circumstances, I will be charged a small copying fee.

Research and Program Management:
I understand that my child's clinical materials, such as information obtained through assessment and testing results, may be used for program management, research, and training purposes. Confidentiality is protected and no identifying information is used for research purposes unless I have signed a separate research consent form stating otherwise.

Authorization to Release to the Insurance Company:
I authorize The Watson Institute to release all or part of my child's mental health and medical record by telephone, by encrypted email, by facsimile transmission, or in writing when required or permitted by law or governmental regulation, or as a condition for payment of charges from insurance carriers, third party reimbursors, utilization review bodies, or welfare funds. This authorization also extends to any organization acting on behalf or in place of the insurance companies. The Watson Institute and its employees who render services to my child are hereby released from any and all liability that may arise from the release of the information.

Assignment of Benefits:
In the event my child is entitled to medical or mental health benefits of any type arising out of any insurance policy or from any person or organization who is or may become liable to my child to provide such benefits, I hereby assign such benefits to The Watson Institute. Such insurance includes, but is not limited to, private commercial insurance and any governmental program such as Medicare or Medicaid. I certify that the information given regarding my child's insurance is accurate and current.

Financial Agreement:
In consideration of services rendered by The Watson Institute, I individually obligate myself and guarantee prompt payment of all charges incurred for services rendered to my child when not covered by insurance carriers or others. Insurance co-payments and self-pay charges are due at the time of the visit. Payment will be made of any balance due and not paid by insurance carriers or third-parties within 30 days of final billing. If such payment is not received by The Watson Institute within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. If The Watson Institute does not receive such payment within 30 days of the date such balance is due, the bill may be turned over to an attorney or a collection agency, at which time I shall be

liable for attorney's fees and/or collection agency's fees and expenses. I understand The Watson Institute has the right to examine credit bureau files for financial information regarding collection of unpaid debts.

I certify that I have read and understand the above information and fully accept all specified terms therein.

Child's Name: _____ Date of Birth: _____
Print

_____
Child's Signature (if age 14 or older) Date

_____
Parent/Legal Guardian Signature Relationship to Child Date

_____
Witness Signature Date

The Watson Institute

Authorization for Release of Health Information to Primary Care Physician (PCP)

Client Name: _____ Date of Birth: _____

I, _____, hereby authorize The Watson
(printed parent/guardian name)

Institute to disclose to and receive from the primary care physician, all mental health and medical information as may be necessary to monitor the continuity of care and to inform of any change in health status.

PCP Name: _____

PCP Address: _____

PCP Phone: _____ PCP Fax: _____

This authorization becomes effective _____ and may be revoked by me in writing at
(today's date)
any time, except to the extent of action already taken. Unless earlier revoked, this authorization automatically expires on _____. The Watson Institute has forms to use
(one year from today's date)
if I wish to revoke this Authorization at any time before it expires.

- I understand that the information released relates to the medical, mental health, and/or drug and alcohol treatment provided to me/my child.
- I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have placed my initials here _____.
- I understand that information used or disclosed under this authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protection provided to me by law.
- I understand that I am not required to sign this authorization in order to obtain treatment.
- I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR, Part 2.
- I have read this Authorization, or had it explained to me, and I understand its contents. A photocopy of this Authorization is considered valid.

Watson INSTITUTE

Client's Signature (if 14 years or older) Date Signed

Parent/Guardian Signature Date Signed

Witness Signature Date Signed

If you are the legal representative of the person listed above, please check off the basis for your authority:

- ☐ Parent of Minor
- ☐ Guardianship Order (attach copy)
- ☐ Power of Attorney (attach copy)
- ☐ Other: _____

☐ I do not want the primary care physician to receive information about services provided through The Watson Institute.

The Watson Institute
Office Covid-19 Policies

For parents, patients, and guardians attending in-person appointments in the office:

1. Only one person can attend appointment with patient, and no siblings are permitted to attend
2. Caregivers and patients will remain in their car in the parking lot until staff ask them to enter the building
3. If exposed or have symptoms or confirmation of Covid-19 for anyone in the home, call to reschedule appointment
4. Caregivers will wear masks at all times when in the building
    a. If caregiver refuses, Watson has the right to refuse service
5. If able, patients will wear masks at all times when in the building
6. Once they have entered the building, patients and caregivers will sanitize or wash hands
7. Patients will have a break during testing but no toys/books will be provided in the Watson waiting room
8. Patients are required to eat snacks at designated areas
9. No snacks will be permitted in the evaluation rooms
10. Patients are required to wash/sanitize hands after breaks
11. If staff observes patients or caregivers exhibiting any potential symptoms of COVID-19, a supervisor will be consulted to determine if the patient/caregiver needs to leave and reschedule the appointment.

Background Questionnaire

Child's Name: _____ Gender: _____ Date of Birth: _____ Referral Date: _____

Person Completing Form: _____ Relationship to Child: _____

Child's Home Address: _____

Phone #: (Home)_____ (Cell) _____

Who referred you here? Name: _____ Agency: _____

Main Concerns: _____

_____

Is the child adopted? Yes** No Is the child in foster care? Yes** No

Copies of any custody agreements or relevant Court Orders of who has medical rights will need to be provided so that we know who is entitled to receive records and information. Information is required before an appointment conducted.

Child's Ethnicity:
___ Hispanic/Latino ____Non-Hispanic/Latino

Child's race: (Please mark "multi-cultural" if a child is more than one race)

____Caucasian or white ____African American or Black ____Asian, including South Asian or Indian

____Native Hawaiian or Pacific Islander ____Native American Indian, Native Alaskan or Inuit

Multicultural/Other: Please specify _____

FAMILY HISTORY

	Biological Mother	Biological Father	Legal Guardian(s)
Name:			
Age:			
Address:			
City, State, Zip:			
Phone:			
Years of Education:			
Learning Problems:			
Current Job:			
Emotional Problems:			
Substance Abuse:			
Medical Problems:			
Genetic Testing:			
Does this person live with the child?	___ YES ___ NO	___ YES ___ NO	___ YES ___ NO

Are the biological parents: ☐ Married ☐ Together ☐ Separated ☐ Divorced ☐ Never Married

If the parents are remarried or live with a significant other, please provide information:

Name: _____
Age: _____
Relationship: _____
Current Job: _____
How long has person known child: _____

Name: _____
Age: _____
Relationship: _____
Current Job: _____
How Long has person known child: _____

Please list the siblings (Full, Half, Step, Adoptive/Foster) of the child and circle the names of those who live with the child.

Name	Age	Relationship	Grade/Job	Learning, emotional, or medical problems

List anyone *who lives in the household* who is **NOT** a parent, guardian or sibling, and the *relationship* to the child:

_____
_____

Please list anyone in the family who has had any medical problems, mental health diagnoses, or substance abuse issues.

_____
_____
_____

PREGNANCY, BIRTH, AND DEVELOPMENTAL HISTORY

Mother's age at child's birth: _____ Father's age at child's birth: _____

While pregnant, what medications (prescribed or over-the-counter) did the mother take: _____
_____
_____

Any health problems during pregnancy? _____

Did the mother receive regular prenatal care? ☐ Yes ☐ No

Was the child delivered: ☐ Vaginally ☐ Cesarean Section

Did the mother use any of the follow substances during pregnancy?

☐ None ☐ Caffeine ☐ Tobacco ☐ Alcohol
☐ Marijuana ☐ Other Drugs (Cocaine, Heroin, etc.) ☐ Unknown

Was child born: ☐ Early: _____ ☐ On time (37-42 weeks): _____ ☐ Late: _____

How much did the child weigh at birth? _____ lbs. _____ oz.

Did the mother have any problems with delivery? ☐ Yes ☐ No
If so, please describe: _____

Did the child have any problems during the first year of life? ☐ Yes ☐ No
If so, please describe: _____

_____

Motor Skills

Crawled forward:	☐ Early	☐ Average (8-10mnth)	☐ Late	☐ Not Yet
Walked alone (2-3 steps):	☐ Early	☐ Average (11-13mnth)	☐ Late	☐ Not Yet

Language abilities

Said "dada" or "mama":	☐ Early	☐ Average (11-14mnth)	☐ Late	☐ Not Yet
Said other single words":	☐ Early	☐ Average (12-14mnth)	☐ Late	☐ Not Yet
Used two-word sentences:	☐ Early	☐ Average (20-24mnth)	☐ Late	☐ Not Yet

Does your child have toileting issues? _____

HEALTH HISTORY

What hand does the child use most? ☐ Right ☐ Left ☐ Use both equally

Has your child's vision been tested? ☐ Yes ☐ No

If yes, what were the results? _____

Corrective lenses? ☐ Yes ☐ No

Has your child's hearing been tested? ☐ Yes ☐ No

If yes, what were the results? _____

Was the child ever admitted to a hospital? ☐ Yes ☐ No

If so, please describe: _____

Has the child had any medical problems? ☐ Yes ☐ No

Describe: _____

Does the child take any medications (prescribed or over-the-counter) currently? ☐ Yes ☐ No

If so, please list what he/she takes, how much, when and why:

Start Date	Medication Name	Dosage	When Taken	Why

Who provides medication management for the child (include name and practice)?

_____

Name of Primary Care Physician/Pediatrician: _____
Address: _____

Specialists Seen: ☐ Developmental Pediatrician ☐ Genetics ☐ Endocrinologist ☐ Allergist ☐ Cardiologist
☐ Other: _____

What therapies have been provided to the child (Please list when and by whom):

☐ No therapies ☐ Occupational Therapy: _____

☐ Physical Therapy: _____ ☐ Speech Therapy: _____

☐ Psychotherapy or counseling: _____ ☐ Other: _____

If any, what evaluations has the child had, and when?

☐ Neurological examination or imaging: _____

☐ Psychiatric / Medication Evaluation: _____ ☐ Psychological or neuropsych testing: _____

_____ _____

☐ Speech and language testing: _____ ☐ School testing/Educational Assessment: _____

_____ _____

Does the child have any current mental health diagnoses (List Below)? ☐ Yes ☐ No

Diagnosis	Professional/Institution providing diagnosis
_____	_____
_____	_____
_____	_____

SCHOOL HISTORY

Name of School District: _____

Name of current school: _____ Current Grade: _____

Was the child ever held back to repeat a grade? ☐ No ☐ Yes Which Grade? _____

Is the child in special education? ☐ No ☐ Yes Beginning When: _____

Does the child have: _____ IEP _____ 504 Plan

Class Type: ☐ Regular classroom ☐ Learning Support ☐ Autism Support ☐ Emotional Support

What kind of grades has the child earned in the past year? (Check all that apply)

☐ A ☐ B ☐ C ☐ D ☐ F

or

☐ Outstanding ☐ Good ☐ Satisfactory ☐ Improvement Needed ☐ Unsatisfactory

****If your child has had testing (Educational or Psychological/Neuropsychological) performed by a School Psychologist, or by a psychologist/neuropsychologist, it is imperative that you bring the reports with you.****

The Watson Institute
Telehealth Consent Form

Patient Name: _____ Date of Birth: _____

I/we consent to participate in telemental health services as part of my psychotherapy session, IBHS session, medication management appointment, or psychological evaluation. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means (ex. video/audio platform or phone) between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions.
7. I understand that my therapist, psychiatrist, or psychologist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
8. I understand that I am advised to choose a private location in my home with minimal interruptions during telehealth sessions.

I have read the information provided above can discuss it with my therapist, psychiatrist, or psychologist. I understand the information contained in this form.

_____

Child's Signature (if age 14 or older) Date

_____

Parent/Legal Guardian Signature Relationship to Child Date

_____

Witness Signature Date

The Watson Institute
Insurance Information

** Please note that Pennsylvania Medical Assistance is always the payor of last resort
**All services at The Watson Institute need to be billed through the child's primary Health Insurance first and then to the Medical Assistance plan (if applicable)

Name of Primary Health Insurance: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____
(as it appears on the insurance card)

Policy Holder Date of Birth: _____

Policy Holder Address: _____
(if different than child's address)

Policy Holder Employer: _____

Name of Secondary Health Insurance: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____
(as it appears on the insurance card)

Policy Holder Date of Birth: _____

Policy Holder Address: _____
(if different than child's address)

Policy Holder Employer: _____

Medical Assistance

Please complete if your child is covered under Pennsylvania Medical Assistance. Medical Assistance is always the payor of last resort.

Name of Child: _____
(as it appears on the insurance card)

County of Residence: _____ State ID Number: _____
(10-digit number)

The Watson Institute
EMAIL Authorization to Release/Request Health Information

Child's Name: _____ Date of Birth: _____

Print

I HEREBY AUTHORIZE:

Provider of Information:	**TO RELEASE TO:**	Recipient of Information:
The Watson Institute 301 Camp Meeting Road Sewickley, PA 15143 Fax #: 412-741-9021 Phone # 412-749-2889		Name: _____ Email: _____

I authorize to use/or disclose my following information (must check at least one):

☐ Mental Health Treatment ☐ HIV/AIDS related
☐ Substance Abuse and/or Treatment ☐ Other _____

Method of release (must check at least one):

☐ Verbal Only ☐ Verbal & Copies
☐ Copies Only ☒ Email

The following specific information will be released:

Medical Records
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Medications
- ☐ Immunization Record
- ☐ Other: _____

Mental Health Records
- ☐ Discharge Summary
- ☐ Psychiatric Evaluation
- ☐ Progress Notes
- ☐ Behavior Reports
- ☐ Social History
- ☐ Treatment Plans/Reviews
- ☐ Psychological Evaluation
- ☐ Testing
- ☐ Medication
- ☐ Other: _____

Education Records
- ☐ Attendance/report cards
- ☐ Evaluation/Reevaluation
- ☐ Scholastic/Achievement Test(s)
- ☐ Other: _____

Effective Dates for Release of Information:

Date: _____ This authorization expires on _____
(Today's Date) (One Year from Today's Date)

Purpose of Disclosure: _____ Continuity of Care _____

- I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent it has already been relied upon. In order to revoke this Authorization, I understand that I must revoke it in writing to the designated provider. The Watson Institute has forms for you to use if you wish to revoke this Authorization at any time before it expires.

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- I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.
- I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.
- I understand that I am not required to sign this Authorization in order to obtain treatment.
- I have read this Authorization, or had it explained to me, and I understand its contents. A photocopy of this Authorization is considered valid.

Child's Signature (if age 14 or older) Date

Parent/Legal Guardian Signature Relationship to Child Date

If you are the legal representative of the client, please check off the basis for your authority:

- ☐ Parent of Minor
- ☐ Guardianship Order (attach copy)
- ☐ Power of Attorney (attach copy)
- ☐ Other: _____

Witness Signature Date

Additional Witness Signature for Verbal Consent Date

EXPIRATION: This authorization is valid for one year from the date of signature, unless the authorization is revoked by written notice.

The Watson Institute
Authorization for Automatic Appointment Reminder Text/Email

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

To help patients remember their mental healthcare appointment, and to reduce the number of missed appointments, patients and their families can be sent an appointment reminder via email or text message to a mobile phone.

If you choose to be reminded via email or text message to your mobile phone, you can stop messages at any time. Contact the administrative assistant to have your email address or mobile phone number excluded from text message reminders.

If you wish to be reminded about your appointment via email and/or text message, please complete the information below:

I authorize The Watson Institute to remind me via email and/or text message of future appointments.
I understand that my email address and/or telephone number will not be used for any other reason.
I understand that I have the option to stop reminders via email and/or text message at any time.

Mobile Number: _____

Email Address: _____

_____
Child's Signature (if age 14 or older) Date

_____
Parent/Legal Guardian Signature Relationship to Child Date

_____
Witness Signature Date

The Watson Institute
Psychological Services Cancellation Policy

It is the intention of the Watson Institute to be flexible in meeting client and family needs.

We have established the following cancellation policy that will hopefully be both flexible and reasonable, as we work together to provide services to your child. Our policy is based on the need to avoid unfilled appointments. This policy is especially important due to the number of families waiting to receive services. Therefore, our policy is as follows:

For Psychological Testing: We request at least a 24-hour notice of all cancellations. Failure to contact us to cancel will result in the cancellation of any remaining appointments. It will be the responsibility of the family to contact us to reschedule the appointments. If the testing series is cancelled/rescheduled 3 times or more, the situation will be reviewed and it will be decided if your child may or may not be scheduled with us for future appointments.

For ALL Other Appointments and Therapy Sessions: We request at least a 24-hour notice of all cancellations. It will be the responsibility of the family to reschedule any missed appointments. In the event of 3 or more consecutive cancellations and/or "no shows," the situation will be reviewed and it will be decided if your child may or may not be scheduled with us for future appointments.

Any patient who arrives later than their scheduled appointment time may be asked to reschedule.

Our main office number is (412) 749-2889. Once we receive notice from you, we will contact the staff members involved. However, because we believe that we are offering a very important service to your child, we sincerely hope that you would not feel the need to cancel, except in case of illness or family emergency. We will also extend the same courtesy to you, in the event that our staff needs to cancel for the same or similar reasons.

Please feel free to contact us if you have any questions about this policy. We remain available to work with you and your child in making the best possible use of this important service.

Child's Name: _____ Date of Birth: _____
Print

_____
Child's Signature (if age 14 or older) Date

_____
Parent/Legal Guardian Signature Relationship to Child Date

The Watson Institute
HIPAA and Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. **You have the right to:**

- Get a copy of your paper or electronic medical record
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Please ask for more information if you're interested.
  - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Correct your paper or electronic medical record
  - You can ask us to correct health information about you that you think is incorrect or incomplete. Please ask for more information if you're interested.
  - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communication
  - You can ask us to contact you in a specific way (for example, home, or office phone) or to send mail to a different address.
  - We will say "yes" to all reasonable requests.
- Ask us to limit the information we share
  - You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared your information
  - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
  - We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice
  - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you believe your privacy rights have been violated
  - You can complain if you feel we have violated your rights by contacting us using the information on the Complaints and Grievance Procedure document.
  - You can file a complaint with the U.S. Department of Health and Human Services by visiting:

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http://www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
- *If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
- **In these cases, we *never* share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
- **In the case of fundraising:**
  - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- **To Treat you**
  - We can use your health information and share it with other professionals who are treating you if a release of information is signed. ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
- **To run our organization**
  - We can use and share your health information to run our practice, improve your care, and contact you when necessary. ***Example:*** *We use health information about you to manage your treatment and services.*
- **To bill for your services**
  - We can use and share your health information to bill and get payment from health plans or other entities. ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions within the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

- **To help with public health and safety issues**
  - We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety

- **To do research**
  - We can use or share your information for health research.
- **To comply with the law**
  - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **To work with a medical examiner or funeral director**
  - We can share health information with a coroner, medical examiner, or funeral director when a person passes away.
- **To address workers' compensation, law enforcement, and other government requests**
  - We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- **To respond to lawsuits and legal actions**
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- Please note the following:
  - We do not maintain psychotherapy notes at this practice
  - We do not share information with organ procurement organizations

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

The Watson Institute
Complaint and Grievance Procedures

It is our goal to provide services in such a manner that consumers will have no cause for complaint. If you ever have a concern or disagreement about your services, please let us know so we can help resolve the situation to your satisfaction.

Please discuss your issue with the staff person who is involved, such as your evaluator or therapist. If you cannot discuss the issue with them or if the discussion does not help, talk or write to the staff person's supervisor. If you do not know who the supervisor is, please call our administrative assistant at 412-749-2880. The administrative assistant will ask the supervisor to contact you.

If you do not feel as if your problem has been resolved after talking to the staff person's supervisor, call or write to the Director of Psychological Services at 301 Camp Meeting Road, Sewickley, PA 15143 or 412-749-2880. Again, if you have any questions about how to proceed, call the administrative assistant.

You should receive a written response from each of these people within seven working days of the day that you talk to them or they receive your written concerns. They are required to have a response in the mail to you within five working days. If they feel that they need more time for any reason, they will let you know and will respond as quickly as possible.

If you do not feel that your concern has been resolved after going through this process, you have the right to express your concern to the County Mental Health/Intellectual Disabilities Administrator in the county where you live or to your insurance provider/managed care organization. Additionally, you may bring your complaint to the Pennsylvania Office of Mental Health and Substance Abuse Services. You have the right to make a complaint without fear or retribution in any form and that any complaint will be investigated and resolved as needed.

PROCEDURE:

1. Complaint is made to:
    a. The staff involved (therapist, evaluator, etc.)
    b. The staff supervisor
    c. The program director
    d. The Managed Care Organization responsible for your services:
        i. Community Care Behavioral Health Organization
        339 Sixth Avenue, Suite 1300, Pittsburgh, PA 15222
        1-800-553-7499
        ii. Beacon Health Options
        P.O. Box 1840, Cranberry Township, PA 16066-1840
        1-877-615-8502
    e. Allegheny County Office of Behavioral Health
    Bureau of Children's and Adolescent Services
    One Smithfield Street, 3rd Floor, Pittsburgh, PA 15222
    412-350-4456
    f. Office of Mental Health and Substance Abuse Services
    301 Fifth Avenue, Suite 480, Pittsburgh, PA 15222
    412-565-5226
2. If the consumer chooses, the complaint may be presented to the director, who shall respond to the complaint within five to seven working days

Watson
INSTITUTE

3. A complaint may be received by the department orally, by telephone, by mail, during an office visit, or by directly reaching out by the staff
4. A signature of the consumer is not required
5. Consumers may not be subject to retaliation by the director or staff of the department as the result of the submission of a complaint
6. A copy of the department's complaint procedure as described above will be:
    a. Given to every consumer
    b. Signed by consumer and placed in the chart
    c. Posted in the department so that it is available to all consumers

The Watson Institute
Psychological Services Cancellation Policy

It is the intention of the Watson Institute to be flexible in meeting client and family needs.

We have established the following cancellation policy that will hopefully be both flexible and reasonable, as we work together to provide services to your child. Our policy is based on the need to avoid unfilled appointments. This policy is especially important due to the number of families waiting to receive services. Therefore, our policy is as follows:

For Psychological Testing: We request at least a 24-hour notice of all cancellations. Failure to contact us to cancel will result in the cancellation of any remaining appointments. It will be the responsibility of the family to contact us to reschedule the appointments. If the testing series is cancelled/rescheduled 3 times or more, the situation will be reviewed and it will be decided if your child may or may not be scheduled with us for future appointments.

For ALL Other Appointments and Therapy Sessions: We request at least a 24-hour notice of all cancellations. It will be the responsibility of the family to reschedule any missed appointments. In the event of 3 or more consecutive cancellations and/or "no shows," the situation will be reviewed and it will be decided if your child may or may not be scheduled with us for future appointments.

Any patient who arrives later than their scheduled appointment time may be asked to reschedule.

Our main office number is (412) 749-2889. Once we receive notice from you, we will contact the staff members involved. However, because we believe that we are offering a very important service to your child, we sincerely hope that you would not feel the need to cancel, except in case of illness or family emergency. We will also extend the same courtesy to you, in the event that our staff needs to cancel for the same or similar reasons.

Please feel free to contact us if you have any questions about this policy. We remain available to work with you and your child in making the best possible use of this important service.

PARENT COPY

The Watson Institute
HIPAA and Grievance Signature Form

Child's Name: _____ Date of Birth: _____
Print

_____ I have received a copy of The Watson Institute's HIPAA and Notice of Privacy Practices, which provides a complete description of possible uses and disclosures of my/my child's health information.

_____ I have received a copy of The Watson Institute's Complaint and Grievance Procedure form.

_____ I have received a copy of The Watson Institute's Cancellation Policy.

_____
Child's Signature (if age 14 or older) Date

_____
Parent/Legal Guardian Signature Relationship to Child Date

The Watson Institute
Directions to Sewickley Location

Directions to The Watson Institute, 301 Camp Meeting Road, Sewickley, PA 15143

From the North:
Take I-79 south to Emsworth- Sewickley Exit 66; follow signs to Route 65 north (Ohio River Blvd.) to Leetsdale; pass the Quaker Valley Shopping Center on right; turn right onto Ferry Street; at second stop sign, turn right onto Beaver Street; make immediate left onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.

From the South:
Take I-79 north to Emsworth- Sewickley Exit 66; follow signs to Route 65 north (Ohio River Blvd.) to Leetsdale; pass the Quaker Valley Shopping Center on right; turn right onto Ferry Street; at second stop sign, turn right onto Beaver Street; make immediate left onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.

From Beaver and the West:
Route 65 south (Ohio River Blvd.) to Leetsdale; to Quaker Valley Shopping Center on left; turn left into shopping center; follow to back of shopping center to stop sign; turn left onto Beaver Street; pass through first stop sign (at school); before second stop sign, make right turn onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.

From Pittsburgh International Airport:
Take Route 60 north toward Moon Business Area; make left onto University Blvd.; follow down the hill through 4 lights passing car dealerships, Robert Morris University; make left turn onto Sewickley Bridge; turn left off bridge; follow to Leetsdale; pass Quaker Village Shopping Center; turn right onto Ferry Street; at second stop sign, turn right onto Beaver Street; make immediate left onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.

The Watson Institute
Directions to Sharpsburg Location

Directions to The Watson Institute Sharpsburg, 200 Linden Avenue, Sharpsburg, PA 15215

Coming South on Rt. 28:
Take Highland Park Bridge Exit
Take Sharpsburg exit (far right lane) before getting onto bridge
Make a right at the end of the ramp onto Main Street
Make a right at 15th Street
Make a left on Canal
Make a right onto Linden Avenue, immediate right to turn into Watson/LEAP building parking lot

Coming over the Highland Park Bridge, Rt. 8 North:
At the end of the bridge, take the second ramp to the right – Sharpsburg exit
Make a right at the end of the ramp onto Main Street
Make a right at 15th Street
Make a left on Canal
Make a right onto Linden Avenue, immediate right to turn into Watson/LEAP building parking lot

Coming north on Rt. 28, from Downtown, North Side, Millvale:
Bear right for Sharpsburg Exit
Go straight through stop sign, bear right onto Main Street
At Y intersection (Indian statue in the middle), bear left onto North Canal Street
Next intersection, make sharp left onto Clay Street
Make a right onto Linden Avenue, immediate right to turn into Watson/LEAP building parking lot

Coming from Rt. 8 South:
Go straight ahead, toward R.D. Fleming Bridge, as you approach Rt. 28
Take Sharpsburg exit (to the right, past Rt. 28 entrance)
Make a left at the end of the exit ramp, onto South Main Street
South Main Street will merge into Main Street
At Y intersection (Indian statue in the middle), bear left onto North Canal Street
Next intersection, make sharp left onto Clay Street
Make a right onto Linden Avenue, immediate right to turn into Watson/LEAP building parking lot

The Watson Institute
Directions to South Location

Directions to The Watson Institute South, 230 Hickory Grade Road, Bridgeville, PA 15017

From the North:
I-79 South to Bridgeville exit 54 (rt. 50)
Off the exit turn left toward Cecil
at first light turn left on Hickory Grade Road
travel up the hill .8 miles
The Education Center south is on your right
Entrance is under the small overhang to the left of the bus entrance

From the South:
I-79 North to Bridgeville exit 54 (rt. 50)
Off the exit turn left toward Cecil
at second light turn left on Hickory Grade Road
travel up the hill .8 miles.
The Education Center south is on your right
Entrance is under the small overhang to the left of the bus entrance

From Pittsburgh and the East:
Fort Pitt Tunnel and Parkway West to Washington-Erie Exit I-79
South on I-79 to Bridgeville exit 54 (rt. 50)
Off the exit turn left toward Cecil
at first light turn left on Hickory Grade Road
travel up the hill .8 miles
The Education Center south is on your right
Entrance is under the small overhang to the left of the bus entrance