5/8/2020

DISCLOSURE STATEMENT of PAUL D. CONNOR, Ph.D.

Washington State law mandates that each client be provided with the following disclosure information at the commencement of any program of treatment by a licensed psychologist. You are free to ask questions and to discuss concerns regarding this form with the psychologist.

Welcome to my neuropsychological assessment service. Please take the time to carefully read this disclosure statement. It describes my private practice policies, my qualifications, the practice of neuropsychology and how it relates to my services, and your rights as a client. I encourage you to ask any questions that arise, either now or during the course of the assessment. Your feedback is welcome. It is my goal to provide you with the highest quality of neuropsychological services possible.

My Licensure and Qualifications:
I have a Ph.D. in clinical psychology with a specialty in neuropsychology from Brigham Young University. I am a licensed psychologist in Washington State. My license number is PY00002050. Licensure by the state means that I have received a doctoral degree from an accredited university, passed a national written examination and passed an oral examination given by the Washington State Examining Board of Psychology. If more information is needed, you may contact the Examining Board of Psychology, Department of Health, 1300 SE Quince St., EY 21, Olympia, WA 98504.

My professional background involves neuropsychological assessments of individuals with a variety of neurological impairments. This can include traumatic brain injury, strokes, dementia, and Fetal Alcohol Spectrum Disorders to name a few. For over 13 years I conducted research into the damaging effects of prenatal alcohol exposure on both the structure and function of the brain. Prior to that, I had four years of experience conduction general neuropsychological evaluations for a wide range of conditions.

What is a Neuropsychological Assessment?
A neuropsychological evaluation is an in-depth assessment designed to identify brain-related areas of strength and deficit.

The assessment procedure includes an interview combined with one-on-one testing, designed to determine current brain functioning. Assessments, test interpretation, report preparation, and feedback sessions are conducted by a licensed psychologist with a specialty in neuropsychology.

Neuropsychological exams are most frequently performed following a neurological based change in functioning. Changes may occur for a variety of reasons, such as traumatic brain injury, stroke, tumor, prenatal alcohol exposure, toxic chemical exposure, or degenerative conditions (such as multiple sclerosis or dementia). This type of evaluation can also be useful in identifying learning disabilities and attention deficits.

What Services do I Provide?
I offer adults (17 & over) a comprehensive neuropsychological evaluation designed to assess cognitive function, mental health status, and adaptive behavior. Evaluations combine a clinical interview, neuropsychological testing, and a review of previous psychological or psychiatric records.

The assessment often involves two scheduled clinic visits: an assessment lasting approximately 5 hours, and a 1-hour reporting conference that occurs a few weeks later. If the evaluation is being sought by a 3rd party agency, the follow-up reporting conference will occur at their discretion.

Consultations with current health providers and referrals to community resources occur as needed. In cases where Fetal Alcohol Spectrum Disorders are suspected, facial photographs may be taken and analyzed for facial features often associated with this condition.

I do not offer ongoing psychotherapy or case management; however, I am available for follow-up consultation.

Financial Responsibilities:
The fees and requirements for payment for my service can be found on the Financial Agreement Form. Regarding cancellation of appointments; since the appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for rescheduling or cancellation. The Financial Agreement Form discusses fees for cancellations on a shorter notice than 48 hours.

Insurance and Managed Health Care Issues:
With the exception of some forms of Medicare and Medicaid, I do not bill third party payers (e.g. insurance companies or HMO's). All payments are required at the time the service is provided. However, I am happy to fill out forms for you to submit to your insurance company so that you can apply to gain reimbursement from them for the services. It is often helpful or required that you obtain a referral from your primary caretaker (general practitioner, specialist doctor, or psychiatrist) in order for your insurance company to reimburse you for the services. I would be happy to provide wording that can be used for a referral.

Confidential Communication:
All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion that the client presents a danger of violence to others, or where the client is likely to harm him-herself unless protective measures are taken. Disclosure my also be required in the case of a court order. I will inform you if conditions for disclosure arise and will clarify any limits to confidentiality between minors and legal guardians at the outset of services.

Access to Records:
I keep a record of the services I provide to you. You may ask to see and copy that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it by putting your request in writing and submitting it to my office. A response to your request will be made within 15 days; this is in compliance with RCW 70.02.080. Justifications for denial of your request to access records include the possibility of injury or harm to the client. The requests may reveal the identity of a person who provided information in confidence. The disclosure may endanger others. Clients may be charged to copy the record, and a fee may be charged for searching, editing, and copying. We may collect the fee before releasing the records.

Client Rights and Responsibilities:
It is the responsibility of the client to choose the provider and treatment modality that best suits his or her needs. This means that it is the right of the client to refuse treatment. If a different psychologist or type of care would be better suited to you, you may ask the psychologist for a referral to another psychologist, or you may discontinue therapy. You are not obligated in any way to remain with the same service.

In the Case of 3rd Party Referral Cases:
In cases in which you were referred for neuropsychological evaluation by a 3rd party agency (e.g. DVR, DCYF, DDA, L&I, Attorneys, etc.) as one of their clients, the assessment will be paid for by that agency and you will not be financially responsible for the cost. However, in these cases, the agency is my client, not you. This means that what you and I discuss is not confidential. Information that you provide and the test results will become part of the report that will be submitted to the agency for their stated purpose. However, you have the right to refuse to answer questions if you are not comfortable with them. As the agency referring you is my client, they should be contacted if you wish to receive a copy of the report after it has been completed.

5/8/2020

Informed Consent:

My signature below is acknowledgement that I am the client or the person authorized to consent for psychological care for the client, that I have read and understand the disclosure information provided by the psychologist, and that I have received a copy of this disclosure form. Authorization is hereby granted for any diagnostic procedures determined appropriate by Dr. Connor.

______________________ ______________ __________________________
Client's Name (Printed) Date Person Authorized to Consent

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Client's Signature

______________________ _______________
Witnessed Signature Date