West County Psychological Associates

1215 Fern Ridge Parkway
Suite 110, St. Louis, MO 63141

(314) 275-8599

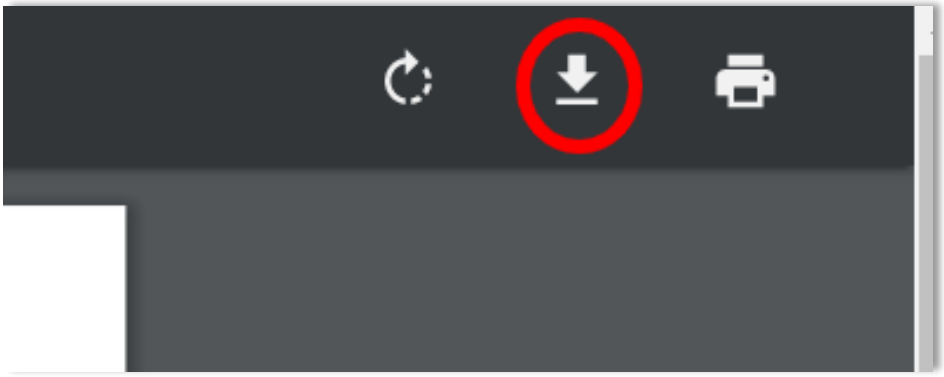
wcpastl.com

Instructions

Download the Form

You must view this form in Acrobat to successfully save your data. Please download this document as shown below (upper right-hand corner)

Then complete the form and save to your computer. For security purposes, completed forms must be uploaded to www.wcpastl.com/upload. Please do not send forms to any of our email addresses.



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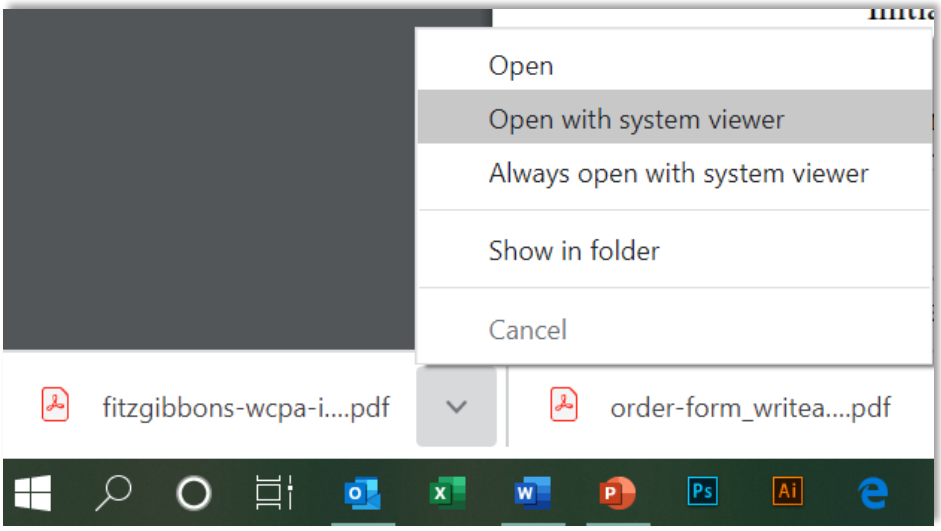

WEST COUNTY PSYCHOLOGICAL ASSOCIATES
1215 Fern Ridge Parkway, Suite 110
St. Louis, Missouri 63141
314-275-8599

Fee Agreement for
Murisa Begic-Gusic, Psy.D.

Giving you the best possible service with consideration for your well-being is of utmost importance to us. The following is some information concerning fee schedules and payment procedures.

Individual session (50 minutes)	$155.00
Psychological Testing/Assessment $180 due at initial interview $500 due at time of testing Remainder due when report is issued	$180.00/hr

Payment is due at completion of the session.
A Mastercard or Visa credit card account number and expiration date is required to guarantee payment. *The credit card will not be charged as long as there is no balance on the account.* If the balance has not been addressed, we will notify you that your credit card will be charged. Please fill in your credit card information on the Billing Information sheet.

Also, we offer Mastercard/Visa services to our clients. If you are interested in charging your visits to either your Mastercard or Visa Account, please fill in the space provided on the Billing Information sheet.

If the fees are covered by insurance, we will be happy to furnish you with an itemized statement for you to submit to your insurance company for reimbursement.

Should you need to cancel an appointment, we require 24 hours notice. Those sessions cancelled without 24 hours notice, other than those cancelled due to emergency, will be charged full fee. In order to cancel, you MUST contact the WCPA office via our office phone number and leave a message for me on my private office voicemail. The office number is 314.275.8599. Cancellations made via email, text, or verbal message to a secretary may still be charged. Thank you for your cooperation.

I fully understand and agree to the above stated terms.

Please print name here

Signature

Date

WEST COUNTY PSYCHOLOGICAL ASSOCIATES

BILLING INFORMATION

Name of Client(s): _____

_____

Person responsible for payment of services:
*Please only include phone numbers where you prefer to be contacted and where we may leave a message.
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Cell Phone: _____
E-mail Address: _____

Employer: _____
Telephone: _____
Social Security Number: _____

Spouse's Name: _____
Spouse's Employer: _____
Spouse's Telephone: _____ Cell Phone: _____
Spouse's Social Security Number: _____
E-mail Address: _____

Referred by: _____

West County Psychological Associates will provide you with an invoice after each visit which you may mail to your insurance company if you are planning to file.

I accept financial responsibility for expenses incurred at West County Psychological Associates by the above named client(s).

___ Please charge my credit card for each visit
___ I will pay by check or cash at the time of my visit

_____ _____
Signature of Responsible Party Date

***Required Information**
Mastercard/Visa Account # _____ Expiration Date: _____
Security Code: _____

West County Psychological Associates

Initial Information for Testing Services

Client's name: _____

Name of person completing this form: _____

Person completing this form is: ___ self ___ parent ___ other: _____

Instructions: *Please answer the following questions about the client. If you are completing this form for your child, please answer each question in regard to your child, not to yourself.*

I. Basic information:

Today's date: _____ Client's age: _____

Date of birth: _____ Client's race/ethnicity: _____

Home phone #: _____ Cell phone #: _____

Please check if we may leave messages at your: ___ home phone ___ cell phone

Home address & zip code: _____

Referred by: _____

II. Reason for seeking evaluation at this time:

_____

_____

_____

_____

_____

III. Client's Medical History

Has the client ever been previously evaluated for mental health or learning concerns, by a school, mental health clinician, medical professional or anyone else? ___ yes ___ no

Please list any previously diagnosed mental health conditions and/or learning disabilities:

_____

_____

Date of last physical exam/"well child" exam: _____

Please list all of the client's current prescription medications and the name of the prescribing doctor(s): _____

Please list all of the client's previous (non-current) medications for mental health concerns:

_____

Has the client previously seen a professional for counseling / therapy? ___ yes ___ no
If yes, please provide the name of the professional and approximate dates of treatment:

_____

_____

IV. Current Problems: *(please mark any the client is experiencing)*

- ☐ Depressed/Irritable Mood
- ☐ Changes in Sleep
- ☐ Changes in Appetite
- ☐ Crying Spells
- ☐ Fatigue
- ☐ Problems Concentrating
- ☐ Suicidal Thoughts/Attempts
- ☐ Difficulty Paying Attention
- ☐ Often Loses Things
- ☐ Doesn't Follow Instructions
- ☐ Difficulty Organizing
- ☐ Easily Distracted
- ☐ Often Forgetful
- ☐ Aggressive toward People
- ☐ Aggressive toward Animals
- ☐ Destructive toward Property
- ☐ Setting Fires
- ☐ Sexually Aggressive
- ☐ Cutting or Harming Self
- ☐ Stealing

- ☐ Elevated Mood
- ☐ Feeling Restless/On Edge
- ☐ Impulsive Behavior
- ☐ Decreased Sleep
- ☐ Agitation
- ☐ Rapid Speech
- ☐ Racing Thoughts
- ☐ Fidgets
- ☐ Squirms in / Leaves Seat
- ☐ Talks Excessively
- ☐ Runs/Climbs Excessively
- ☐ Difficulty with Being Quiet
- ☐ Difficulty Awaiting Turn
- ☐ Hallucinations
- ☐ Bedwetting (Enuresis)
- ☐ Bedsoiling (Encopresis)
- ☐ Refusing to Attend School
- ☐ Alcohol or Drug Abuse
- ☐ Difficulty with Social Skills
- ☐ Sensory sensitivity

- ☐ Feeling Nervous/Worried
- ☐ Unrealistic Fears
- ☐ Feelings of Panic
- ☐ Social Anxiety
- ☐ Repetitive Behaviors
- ☐ Nightmares
- ☐ Flashbacks
- ☐ Often Loses Temper
- ☐ Argues with Adults
- ☐ Defies Rules
- ☐ Deliberately Annoys People
- ☐ Seems Angry and Resentful
- ☐ Easily Annoyed/ "Touchy"
- ☐ Fear of Gaining Weight
- ☐ Recurrent Binge Eating
- ☐ Self-Induced Vomiting
- ☐ Excessive Exercise
- ☐ Tantrums/Fits
- ☐ Unusual habits/behaviors
- ☐ Inflexible routines/rituals

Please list any additional concerns not mentioned above: _____

_____

V. Developmental Background: *If information is unknown, please leave blank.*

Client's parents are: ___ biological ___ adopted ___ other: _____

Length of pregnancy: _____

Any major complications during pregnancy: _____

Alcohol/drug/tobacco use by mother during pregnancy: _____

Type of delivery: _____

Health of client at delivery: _____

Early temperament: _____

Age at which the client began walking: _____

Age at which the client was toilet trained: _____

Early speech (please note any concerns or delays with early speech/language): _____

_____

Has the client ever experienced seizures? ___ yes ___ no

Has the client ever experienced tics or involuntary movements? ___ yes ___ no

Has the client ever experienced a head injury? ___ yes ___ no

Has the client ever been exposed to lead? ___ yes ___ no

If yes on any, please describe: _____

_____

Date of most recent vision exam and results: _____

Date of most recent hearing exam and results: _____

Other relevant illness, injuries or physical disabilities: _____

_____

Concerns regarding the client's sleeping or eating: _____

_____

_____

Concerns regarding social skills/experiences/behaviors: _____

_____

_____

Concerns regarding motor skills (gross or fine): _____

_____

Extra-curricular activities / Hobbies / Talents: _____

_____

VI. Client's Family History

Mother: Name _____ Age _____

Occupation _____ Health _____

Quality of Relationship _____

If Deceased: Cause of Death _____

Age at Death _____ *Client's Age at the Death* _____

Father: Name _____ Age _____

Occupation _____ Health _____

Quality of Relationship _____

If Deceased: Cause of Death _____

Age at Death _____ *Client's Age at the Death* _____

Spouse: Name _____ Age _____

Occupation _____ Health _____

Quality of Relationship _____

If Deceased: Cause of Death _____

Age at Death _____ *Client's Age at the Death* _____

Client's parents are *(or were, if deceased)*:

___ married ___ divorced ___ never married ___ living together ___ separated

NOTE: If the client is a minor and parents are separated or divorced, both parents must sign consent for the evaluation unless otherwise indicated in the court ordered parenting plan. A copy of the court's parenting plan MUST accompany this form to the initial interview session.

If applicable, information regarding custody and/or legal parenting plan: _____

_____

_____

Please list step-parents and other parental figures: _____

_____

Names and ages of client's siblings: _____

_____

Names and ages of client's children: _____

_____

Please list all biological family history of mental health or learning concerns:

On the paternal side: _____

_____

On the maternal side: _____

_____

Within siblings: _____

_____

VII. Client's Education/Work History

A. If client is still in school, please complete the following:

School: _____

School's phone number: _____

Name of school contact person(s): _____

Current grade or level: _____

Recent grades/performance: _____

Typical grades/performance: _____

Onset of performance changes: _____

Academic strengths: _____

Academic weaknesses: _____

Please describe all special services currently received at school: _____

_____

_____

Behavioral concerns at school: _____

_____

Concerns noted by teacher(s): _____

_____

Length and difficulty of homework; homework routine: _____

_____

_____

B. If client is an adult and no longer in school, please complete the following:

Educational level obtained: _____

Please describe challenges experienced in school: _____

_____

Please list any special education services received during school: _____

_____

Current employer and position: _____

_____

Length of current employment: _____

Current concerns regarding employment: _____

_____

Job satisfaction level (circle number): (Low) ◯ ◯ ◯ ◯ ◯ (High)

West County Psychological Associates

Informed Consent for Testing Services

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement with West County Psychological Associates (WCPA).

Testing Services

Psychoeducational and psychological testing are collaborative processes between you and a professional clinician to share relevant background information, identify areas of concern, complete formalized testing measures, and discuss testing results and appropriate recommendations. For testing to be most effective, it is important that you take an active role in the process. Testing is not an identical process for everyone. There are many different methods your clinician may use to investigate the problems that you identify together. The type and extent of services that you receive will be determined following an initial interview. If you have any questions about testing procedures, you are always free to discuss them with your testing clinician.

Benefits and Risks

Testing has benefits and risks. Since all mental health services often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, or anger. Benefits may include greater self-understanding and ability to make appropriate life and/or school decisions, among others. Each person's experience and outcomes are unique to their own circumstances.

Confidentiality and Professional Records

The privacy of all records and communications between a client and a mental health clinician is protected by law. In general, we can only release your information, including testing reports, with your written permission. There are a few exceptions to this general rule, including:

- When a valid court order is issued for records and/or testimony on the part of the clinician, the clinician is bound by law to comply with such an order.
- When there is risk of imminent harm to you or to another person, the clinician is ethically bound to take necessary steps to prevent such harm. This notification may include notifying an intended target of violence, notifying the police, informing a family member about the situation, or seeking appropriate hospitalization.
- When there is suspicion that a child or other dependent person has been sexually, physically or mentally abused or neglected, the clinician is legally required to inform the proper authorities.
- Ethical clinicians consult with professional colleagues about their cases, in order to provide clients the best possible services. If your clinician consults with a colleague, your clinician will not share your name or identifying information.

Fees for Additional Services

If you request that your clinician provide non-testing services, such as attending meetings with school officials or other professionals, charges for those services will normally be higher than the usual rate for in-office testing services and are not included in your original testing fees.

If you become involved in legal proceedings that require your testing clinician's participation, you will be expected to pay for his or her professional time even if called to testify by another party. Because of the difficulty of legal involvement, charges for such services are higher than those for regular testing services.

Testing clinicians, at their discretion, may charge for excessive time spent on phone calls. This includes calls you make to the clinician as well as calls the clinician makes to others at your request, such as to your child's school or to your attorney.

Contacts and Emergencies

You may contact your clinician through the WCPA office phone number, (314) 275-8599. In case of an emergency, please call 911 or go to your nearest emergency room. Your clinician is not on-call at all times and may be unreachable. You may leave an emergency message on his or her office voicemail, and your clinician will return your emergency call when they are able.

Minors

Clinicians at WCPA regularly include parents in the testing process with their children. Initial interviews and final sessions, during which the written report is presented, will normally be held with adults only. Parents are responsible for deciding whether and how to share the report's information with their minor child. Your clinician will discuss this with you if you have concerns. WCPA clinicians will notify parents if they believe the minor client is at risk for harm. WCPA clinicians do not see minors under age 18 for psychological testing without parental consent.

In the case of separated or divorced parents, WCPA requires a copy of the legal parenting plan. Unless otherwise stated in the legal parenting plan, both parents must provide signed consent for their minor child to receive testing services and both parents have the right to exchange information with the clinician about the minor child's testing and results.

Electronic Transmissions

WCPA cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any text, email, or internet-enabled communication between you and your clinician involves greater risk to confidentiality than does traditional in-person communication. WCPA strongly discourages electronic communication between clients and their clinicians.

Termination

At any time, you have the right to seek a second opinion with another qualified mental health professional. You also have the right to terminate the testing process at any time. If you choose to do so, your clinician may offer to provide you with names of other professionals whose services you might prefer. You will remain responsible for paying the fees of any portion of the testing process that was completed.

Informed Consent for Testing Services

Consent to Treatment

I voluntarily consent to receive, and/or for my minor child(ren) to receive, mental health assessment, care, testing and treatment. I authorize my clinician through WCPA to provide such professional services. I understand and agree that I will participate in the planning of my testing services and that I may stop these services at any time. By signing below, I acknowledge that I have both read and understood the information in West County Psychological Associates' *Informed Consent for Testing Services* document and agree to its terms. This consent ends when I notify my clinician that I am terminating services or one year following my last appointment.

Note: By signing Consent for Testing Services, I acknowledge that I, or my minor child, will receive diagnoses and/or recommendations that are appropriate according to the clinical judgment of my testing clinician. These diagnoses and/or recommendations may or may not be those that I expected or with which I necessarily agree.

Name of Adult Client(s): _____

Signature of Adult Client(s):

_____ **Date:** _____

_____ **Date:** _____

In the case of a minor client, the signature of a parent is required.

If parents are divorced or legally separated, the signatures of both parents are required unless otherwise stated in the legal parenting plan.

Name /Age of Minor Client(s): _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

The privacy of your personal information is important to West County Psychological Associates (WCPA). WCPA will maintain the privacy of your information and will not disclose your information to others unless you tell WCPA to do so, or unless the law authorizes or requires WCPA to do so.

A federal law commonly known as HIPAA requires that WCPA take additional steps to keep you informed about how WCPA may use information that is gathered in order to provide health care services to you. As part of this process, WCPA is required to provide you with the attached Notice of Privacy Practices and to request that you sign the written acknowledgement that you received a copy of the Notice. The Notice describes how WCPA may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding personal information WCPA maintains about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice please contact WCPA's Director, Dr. Mary Fitzgibbons, at (314) 275-8599.

Notice of Privacy Practices

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.

WCPA is required by applicable federal and state law to maintain the privacy of your health information. It is also required to give you this Notice about privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). It must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about privacy practices, or for additional copies of this Notice, please contact WCPA using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. Permissible Uses and Disclosures without Your Written Authorization

WCPA may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: WCPA may use and disclose PHI in order to provide treatment to you. For example, WCPA may use PHI to diagnose and provide counseling service to you. We may also disclose your information in order to remind you of appointment times. We may disclose your information to any family members or significant others that you voluntarily decide to bring to and include in a therapy session. We may disclose your PHI, with the exception of identifying information, during professional clinical supervision and/or consultation, in order to ethically provide you the highest quality services.

2. Payment: WCPA may use or disclose PHI so that services you receive are appropriately billed and payment is collected. By way of example, it may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: WCPA may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: WCPA may use or disclose PHI when it is required or permitted to do so by law. For example, it may disclose PHI to appropriate authorities if it reasonably believes that you or a child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition it may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law

enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications: WCPA will not use your health information for marketing or fundraising communications without your written authorization. You have the right to opt out of any marketing or fundraising communications that you choose not to receive.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before WCPA can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by WCPA in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, WCPA may deny access to your records. WCPA may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record may not be accessible to you, in accordance with state law. You have the right to an electronic communication of any records that WCPA keeps electronically.

B. Right to Alternative Communications. You may request, and WCPA will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. WCPA is not required to agree to any such restriction you may request. One exception is that, if you self-pay at WCPA, you may request that we not disclose these services to your health insurance company and WCPA is obligated to honor that request.

D. Right to Accounting of Disclosures or Breaches. Upon written request, you may obtain an accounting of disclosures of PHI made by WCPA after October 1, 2003. This right is subject to restrictions and limitations. You also have the right to be notified by WCPA if a privacy breach of your PHI has occurred. If such a breach occurred, you would be notified within a reasonable time.

E. Right to Request Amendment. You have the right to request that WCPA amend your health information. Your request must be in writing, and it must explain why the information should be amended. WCPA may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that WCPA has violated your privacy rights, you may contact the **Privacy Officer,** Director Mary Fitzgibbons, Ph.D., at (314) 275-8599. You may also file written complaints with the

Director, Office for Civil Rights of the U.S. Department of Health and Human Services. WCPA will not retaliate against you if you file a complaint with the Director or the Privacy Officer.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on October 1, 2013.

B. Changes to this Notice. WCPA may change the terms of this Notice at any time. If WCPA changes this Notice, it may make the new notice terms effective for all PHI that it maintains, including any information created or received prior to issuing the new notice. If WCPA changes this Notice, it will post the revised notice in the waiting area of the office and on our website. You may also obtain any revised notice by contacting the Privacy Officer.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for West County Psychological Associates.

_____ _____

Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Name of Client: _____

Personal Representative's Name: _____

Relationship to Client: _____

Authorization to Release Health Care Information

IN CASE OF EMERGENCY

Client name: _____ Date of birth: _____

West County Psychological Associates has my permission to contact the following person in case of emergency:

Name(s): _____

Address: _____

City, State, Zip: _____ Phone Number: _____

WCPA will only exchange information pertinent to the emergency.

This authorization ends: _____ on _____ (date); or

_____ when the following occurs:

_____

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from WCPA; or
2) Write, sign and date a letter to WCPA to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

I understand that once WCPA gives out information, WCPA has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I understand that I am agreeing to the exchange of health care information regarding receiving testing and/or treatment for psychiatric disorders, mental health, behavior, and/or drug and/or alcohol use.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.