ODYSSEY WELLNESS

3067 E. Warm Spring Rd., Ste. 100
Las Vegas, NV 89120
O: 702.202.0000
F: 702.710.6521

Psychological Evaluation and Informed Consent Statement

Department of Family Services (DFS)

Overview of Evaluation:
The Department of Family Services, (hereinafter referred to as "DFS") has requested that you undergo a psychological assessment. Odyssey Wellness is an agency employing licensed psychologists and other mental health personnel, supervised by Dr. Sarah Ahmad, (hereinafter collectively referred to as "psychologist") experienced in conducting such assessments and who will perform the psychological evaluation. The assessment may consist of standardized written psychological testing, an oral interview, and a review of collateral or third-party information made available by DFS or by you. This may include information gathered from your case worker/manager throughout the evaluation process.

The assessment may also include a review of prior assessments if the psychologist previously evaluated you or a prior assessment is provided for consideration. Both the written inquiries and interview may probe public and private aspects of your life. These inquiries are necessary to adequately assess the questions posed by DFS. If at any time you wish to ask about the relevance of any question asked in the interview please ask and you will receive an explanation as to why the requested information is needed. *As with any procedure, you have the right to terminate the assessment at any time, although your decision to do so will be reported to DFS with the reason as to why the evaluation was discontinued.* _____***Initials***

Limits of Confidentiality:
Although DFS is the psychologist's client, not you, the psychologist nevertheless will be mindful of his/her duty to conduct the evaluation with fairness and objectivity. You specifically understand and agree that you are not receiving treatment or health care from the psychologist, and that the psychologist does not consider him/herself to be treating you. You understand that you are not being examined for any purpose relating to your personal treatment or your personal health care. Because the psychologist is conducting this evaluation at the request of DFS and for reasons having nothing to do with treatment or health care, you do not have doctor-patient or psychotherapist-patient privilege in your communications with him/her. Therefore, you understand and agree that anything you say or do during and in connection with the evaluation is entitled to disclosure and is *not confidential*, and may be disclosed to others involved in your case with DFS. DFS requires a report of pertinent findings, conclusions, and recommendations, following the completion of the assessment.

DFS may authorize release of the records associated with this assessment, including any written report, to any other qualified professional. Circumstances leading to such release may include a mandatory fitness-for-duty evaluation, disability claim, or other medical evaluation. State law may also require disclosure of otherwise confidential information for reasons associated with, but not limited to, risk of child abuse, a threat of serious harm to yourself or others, or court order. _____***Initials***

Report of Findings and Conclusions:
Following the completion of the examination, the psychologist will give DFS a written and/or oral report of relevant findings and conclusions relating to their referral questions. These reports are necessary to fulfill the purpose for which you have been referred. The reports will necessarily contain private information, although the psychologist will make a good-faith effort to restrict the disclosure of private information to the minimum necessary to satisfy the purpose of the examination and to support his/her findings, conclusions, and recommendations. If the findings, conclusions, opinions, or recommendations are challenged in an adjudicative forum, the psychologist may make full disclosure of all information as may be necessary in its defense and/or as required by law. _____***Initials***

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Waiver of Access to Report and Records:
This assessment is conducted solely for DFS to address relevant concerns with their involvement in your case. You will not be provided a copy of any report the psychologist provides DFS. Because DFS is the client, your authorization will not permit the psychologist to release or disclose the report to you or any third party. You specifically waive any and all statutory rights to access and review personal health care or any other information as it pertains to this examination, if any, whether arising under state or federal statutory, regulatory or common law, including but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended, the Nevada Revised Statutes concerning Confidentiality of Medical Information, and the Nevada Administrative Code, and therefore have no rights to access or review the notes, reports, tests, analyses or other information generated in connection with this evaluation. Even if some of the information contained or produced in this assessment might otherwise be accessible to you, this information is inextricably interwoven with other confidential data to which you otherwise would not be entitled. Therefore, you agree to exonerate, release, and discharge psychologist and DFS, its officers, agents, or assigns, from any claim or damages, whether in law or in equity, on behalf of yourself, your heirs, agents, or assigns, for their refusal to make available any and all information contained in this psychological evaluation. _____***Initials***

Payment for Services:
DFS is compensating the psychologist for these services. However, the psychologist will remain objective and neutral. As such, s/he will have sole control over the examination and their resulting opinions, conclusions, and recommendations. _____***Initials***

Potential Outcomes and Uses of the Examination Results:
As a result of this examination, the psychologist will provide their findings to DFS. Regardless of the conclusions the psychologist will reach and communicate in their report or orally, DFS may choose not to rely on their findings and recommendation, in whole or in part, when making decisions about your case. _____***Initials***

Regarding Your Freedom to Decline to Participate:
You are free to decline participation in this examination. However, your decision not to participate in the examination will be communicated directly to DFS and may be perceived unfavorably with regards. _____***Initials***

Re-disclosure:
The psychologist will advise DFS to maintain the written report in a confidential file and that the information should be made available only to persons who have a bona fide need to know the information included in the report. Nevertheless, by signing the authorization attached hereto as Exhibit 'A' and authorizing the psychologist to release this information to DFS, there is the possibility that DFS could re-disclose this information. By signing the authorization, you will expressly release psychologist from any liability for disclosure to DFS, and re-disclosure by DFS. _____***Initials***

Recording and/or Photographing During the Evaluation:
You are not authorized or permitted to photocopy, photograph, record (audio or video) or capture any portion of the evaluation, in whole or in part, including but not limited to written testing, personal history questionnaires, oral interview, and conversations with the psychologist, whether in-person, by telephone, or via telehealth communication. This prohibition applies to all forms of recording, whether digital or analogue. By agreeing to proceed with this examination you agree to accept this prohibition and any civil and/or criminal consequences for violating it. Unilateral recording of verbal statements, in person or electronically, is a felony in Nevada. _____***Initials***

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Expiration Date:
This contract will expire one year from the date of signing or will remain in effect for the period reasonably needed to complete this assessment. However, the contract can be revoked at any time. _____***Initials***

Consent and Signature of Applicant

Note: If you do not have adequate time to review this form, you do not understand it, or if you require additional time to consult with an attorney or other advisor, you may reschedule this examination for a later time by checking the box below, initialing it, and immediately informing the psychologists or their administrative assistant.

❑ *I require additional time to consult with my attorney or other advisor.*
_____ Initial only if you require additional time

❑ *I have read, understand, and agree to the terms of the informed consent statement and waiver of my access rights.* ***I do not require additional time*** *to consult with my attorney or other advisor.*
_____ Initial only if you *Do Not* require additional time

_____	_____	_____
Applicant's Signature	Applicant's Printed Name	Date

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EXHIBIT 'A'

Authorization to Use and Disclose Protected Health Information

I authorize psychologist to use and disclose their findings and opinions concerning my past, present or future physical or mental health or condition, as well as their conclusions, opinions, and recommendations as to findings from this psychological evaluation. ***This Authorization does not authorize any of my prior or current health care providers to disclose personal health care records to psychologist or DFS without separate and specific written authorization, except as permitted by law.***

_____ Mental Health information.
You must initial this item in order for the examination to be conducted.

I understand that the psychologist will make a good-faith effort to restrict the disclosure of private information to the minimum necessary to satisfy the purpose of the examination and to support the findings, conclusions, and recommendations. Consistent with the provisions of state and federal law, I understand that DFS will maintain any written report provided to it by the psychologist. I have been informed that I will not receive a copy of the written report, nor will I be able to authorize its release to any other person or party. I specifically waive any statutory rights to access and review personal health care information as it pertains to this examination.

I acknowledge that the psychologist has no control over how DFS uses the report once it receives it. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. I expressly release psychologist from liability for that re-disclosure. However, I also understand that federal or state law may restrict re-disclosure of mental health information and drug/alcohol diagnosis, treatment or referral information.

Applicant's Signature	Applicant's Printed Name	Date

*****SIGN ON THE FOLLOWING PAGE TO AUTHORIZE USE AND DISCLOSURE OF** PROTECTED HEALTH INFORMATION***

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Signature of Applicant – Authorization to Use and Disclose Protected Health Information

You do not need to sign this authorization. However, your refusal will mean that the required psychological evaluation will not take place. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made prior to your withdrawal of authorization cannot be undone, and you waive any right to an action for damages.

To revoke this authorization, please send a written notice, stating that you are revoking this authorization, to:

Odyssey Wellness
Dr. Sarah Ahmad
Licensed Psychologist
Attn: Records Dept.
3067 E. Warm Springs Rd, Suite 100
Las Vegas, NV 89120

I have read this authorization and I understand it. Unless revoked, this authorization expires one year from the date below.

Applicant's Signature	Applicant's Printed Name	Date

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CONSENT FOR CONFIDENTIAL COMMUNICATION THROUGH ELECTRONIC MEANS

Client Name: _____ Date of Birth: _____
(Last) (First) (MI) (Month/ Day/ Year)

Odyssey Wellness complies with HIPAA and other privacy or security laws and standards regarding the access, use, or disclosure of protected health information (PHI) or electronic protected health information (EPHI). Odyssey Wellness requires your consent to communicate your confidential information through electronic means (i.e. telephone, email, etc). Please check the appropriate boxes and initial next to your response.

Home Phone

☐ Yes (____) ☐ No (____) You may contact me at my home phone.
If yes, please list home phone number _____
☐ Yes (____) ☐ No (____) You may leave voice messages at my home number.
☐ Yes (____) ☐ No (____) You may leave a message with members of my family at my home number.
☐ (____) Restrictions: _____

Work Phone

☐ Yes (____) ☐ No (____) You may contact me at my work phone.
If yes, please list work phone number _____
☐ Yes (____) ☐ No (____) You may leave voice messages at my work number.
☐ Yes (____) ☐ No (____) You may leave a message at my employment.
☐ (____) Restrictions: _____

Cell Phone

☐ Yes (____) ☐ No (____) You may contact me at my cell phone.
If yes, please list cell phone number _____
☐ Yes (____) ☐ No (____) You may leave voice messages at my cell number.
☐ Yes (____) ☐ No (____) You may text me at my cell number.
☐ (____) Restrictions: _____

Email

☐ Yes (____) ☐ No (____) You may contact me at my email address.
If yes, please list email address: _____
☐ Yes (____) ☐ No (____) You may send unencrypted email/ documents.
☐ Yes (____) ☐ No (____) You may email the following information:
☐ Yes (____) ☐ No (____) General inquiries (i.e. appointments, requests, etc.)
☐ Yes (____) ☐ No (____) Reports, treatment plans, etc. related to treatment which includes specific details about my mental health and/ or treatment.
☐ (____) Restrictions: _____

I authorize Odyssey Wellness to communicate confidential information to me by the means indicated above and understand that Odyssey Wellness is not responsible for any re-disclosure based upon the consent provided.

Client Signature: _____ Date: _____
Legal Guardian: _____ Date: _____
Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES
Health Insurance Portability and Accountability Act (HIPAA)

This notice described how medical information about you may be used/ disclosed and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services if referred to as "protected health information" (PHI) and for the purposes of this notice includes electronic PHI (ePHI). This notice of privacy practices describes how we may use and disclose your PHI in accordance with applicable laws and ethical standards. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of privacy practices. We reserve the right to change the terms of our notice of privacy practices at any time. Any new notice of privacy practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised notice of privacy practices by posting a copy in our lobby, sending a copy to you in the mail at your request or by providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members associated with Odyssey Wellness. We may disclose PHI to any other consultant or third party provider only with your authorization.

FOR PAYMENT. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teach purposes, PHI will be disclosed only with your authorization.

AS REQUIRED BY LAW. Under the law, we must disclose your PHI to you upon your request. In additional, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the privacy (and/or security) rule.

WITHOUT AUTHORIZATION. The following is a list of categories of uses and disclosures permitted by HIPAA without an authorization. Applicable laws permit us to disclose information about you without your authorization only in a limited number of situations.

- **Child abuse or neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse and/or neglect.

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- **Judicial and administrative proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
- **Deceased patients.** We may disclose PHI regarding deceased patients as mandated by law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- **Medical emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family involved in care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, and, for the purpose of identifying a suspect, connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized government functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the department of state
  for medial suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority
  authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or
  disability, or if directed by a public health authority, to a government agency that is collaborating with that public health
  authority.
- **Public safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or
  safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person
  or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research.** PHI may only be disclosed after a special approval process.

VERBAL PERMISSION. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION. Uses and disclosure not specifically permitted by applicable law will be made only with your written authorization, which you may revoke at any time with written notice.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our privacy officer at: **Odyssey Wellness, ATTN: Dr. Sarah Ahmad, 3067 E. Warm Springs Road, Suite 100 Las Vegas, NV 89120. Office: 702-202-0000. Fax: 702-710-8.**

- **Right of access to inspect and copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained In a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions

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about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies ($.65 per page).

- **Right to amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the privacy officer if you have any questions.
- **Right to an accounting of disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than once accounting in any 12-month period.
- **Right to request restrictions.** You have the right to request a restriction of limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to request confidential communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a copy of this notice.** You have the right to a copy of this notice and any subsequent changes.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our privacy officer at : **Odyssey Wellness, ATTN: Dr. Sarah Ahmad, 3067 E Warm Springs Road Suite 100 Las Vegas, NV 89120. Office: 702-202-0000. Fax: 702-710- 6521,** or with the Secretary of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201, or by calling (202) 619-0257. The entire federal laws regarding HIPAA can be found at: http://www.hhs.gov/ocr/privacy/index.html.

WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Odyssey Wellness's Notice of Privacy Practices.

I acknowledge that I understand how Odyssey Wellness may access, use, and disclose my protected health information (PHI). I understand my rights in regards to my PHI and the legal duties of Odyssey Wellness to protect my PHI. I acknowledge that any questions I have regarding my protected health information have been addressed to my satisfaction.

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I understand that I may request another copy of the Notice of Privacy Practices upon request or by visiting a Odyssey Wellness office and viewing a copy of the Notice of Privacy Practices in the lobby.

Client Signature _____ Date _____

Legal Guardian Signature (if minor or legally incompetent person) _____ Date _____

Relationship to Client _____

☐ Client or ☐ Legal guardian refuses to sign acknowledgement.

Reason:

_____

_____

_____

Employee Signature (if Client/Legal guardian refuses to sign) _____ Date _____