Kara Goobic, Psy.D.
Licensed Psychologist

Adult ADHD Center of Washington
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Phone (301) 495-6393 ext. 6
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Patient Informed Consent Statement

HIPAA: I have been given a copy of the Health Insurance Portability and Accountability ACT of 1996 (HIPAA)

Fees: I have been informed of and agree to the charges for services rendered by Dr. Kara Goobic.

Insurance Coverage: I understand that Dr. Kara Goobic is a network provider for Blue Cross Blue Shield Care First PPO plans. For other form of insurance, Dr. Goobic is an *out-of-network* provider. I understand that it is my responsibility to inquire about insurance coverage and to submit insurance claims.

Billing Statements: I understand that Dr. Kara Goobic will provide me with an invoice of services rendered on a monthly basis if I do not use Carefirst Blue Cross Blue Shield Insurance. Invoices can be obtained on a more frequent basis, per my request.

Cancellation Policy: I understand that I will be charged for cancellations made less than 48 hours in advance, except in cases of emergency or inclement weather.

Confidentiality: I understand that Dr. Kara Goobic may not communicate verbally or in writing with any other professional about my case without my written permission except in specific instances outlined in the Policies and Procedures document.

Records Review: I understand that Dr. Kara Goobic requests non-original copies of all records given to her for her review.

Records Retention: I understand that in the case of adults, clinical records will not be kept longer than 5 years following the last session. In the case of minors, records will be kept for 5 years or until the patient's 21st birthday, whichever is later.

- As you know, I work with a group of independent mental health professionals, under the name The Adult ADHD Center of Washington. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and at times office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

Informed Consent: I certify that Dr. Kara Goobic has explained to me what treatment may involve and that I understood what I was told. I also understand that I have the right to withdraw myself and/or my child from treatment at any time.

Printed legal name: _____

Signature: _____**Date:**_____