Consent for Neuropsychological Evaluation

I understand that I am being seen for a neuropsychological evaluation. The evaluation will include an interview, record review, and testing with various measures of attention, motivation, motor and sensory abilities, language and spatial skills, problem solving, memory, intellectual functioning, and emotional or personality functioning. I may request further information about any of these procedures. This evaluation may be scheduled for a full day, but I will be allowed breaks as needed. Another day may be needed to complete assessment.

1) **Typical costs**. A typical evaluation is comprehensive and includes not only the time spent directly with the client, but also time spent reviewing records, scoring the tests administered, interpreting the results, and writing the report. Depending on the complexity of the situation, this can add 4 – 8 hours to the direct contact time. If I am covered by an insurance company that the provider is contracted with (e.g., Anthem/Blue Cross, Aetna, Medicare, Cigna), then the provider will accept that contracted rate plus my copay. Otherwise, the typical cost for a neuropsychological evaluation is **$225/Hour.** Additional information on fees is available upon request.

2) Payment Issues

- **Payment due before session.** My portion of payment is due at time of service, paid before the session, unless arrangements are made in advance.
- **Assignment of benefits.** By signing below, I am authorizing the insurance company to pay benefits to **Fullerton Neuropsychological Services**. When the provider bills the insurance company, payment for services is thereby directed to the provider; if the insurance company accidentally sends the check to me, it is my responsibility to turn the check over to The Neurobehavorial Group. The doctor's office may need to communicate certain summary information to my insurance company in order to obtain authorization and payment for this evaluation.
- Self-Pay. A reduced rate is offered for those people who would like to pay in full at time of service. In a self-pay arrangement, the biller will assist me in billing my insurance company, but will leave that ultimately between me and my insurance company.

3. I am welcome and encouraged (but not required) to bring my husband/wife/spouse or significant other to the interview and feedback sessions.

I understand and agree with the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Guardian, if applicable Date

Limits of Confidentiality (Evaluations)

Information discussed in the neuropsychological or psychological evaluation will be incorporated into the Neuropsychological (or Psychological) Evaluation report.

- This report will be sent to the referring source and any other individuals/agencies identified on the Release of Information signed prior to the evaluation.
- If the fee for this evaluation is being paid by an insurance company or other agency, it may be necessary to send a copy of the report to that agency to secure reimbursement, as noted in the signed Authorization for Payment of Benefits.
- The client may request a report be sent to another person or agency at any time in the future by completing an additional Release of Information.
- This report, and any other information discussed in the evaluation, is confidential, and it will not be shared without written permission except under the following conditions:
  5. The client threatens suicide.
  6. The client threatens harm to another person(s), including murder, assault, or other physical harm.
  7. The client reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
  8. The client reports abuse of the elderly and/or if elderly client appears to be neglectful of self.

State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies.

In addition, if the client is involved in a legal action and claims mental health issues related to the legal action (i.e., plea of "Not Guilty by Reason of Insanity," or claiming emotional harm in a lawsuit), mental health records may be required to be released.

Communications between the provider and the client will otherwise be deemed confidential as stated under California state law.

Having read and understood the above, I agree to the limits of confidentiality.

_____ _____

Name of Client (and Guardian, if applicable) Date

_____

Signature of Client

_____

Signature of Guardian

_____

Provider

13 Orchard Rd., Suite 103 Lake Forest 92630
(949) 556-9190 · FAX (714) 773-4788

I have read, understand, and agree to comply with the above information.

Signature of Patient/Guardian

Printed Name

Date

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NBG
CLINICAL PSYCHOLOGY & NEUROPSYCHOLOGY

Billing Policy

CO-PAYMENTS AND/OR DEDUCTIBLE BALANCES WILL BE COLLECTED AT THE TIME OF SERVICE. Co-payments and deductibles are the responsibility of the patient. Extended unpaid balances for deductibles and/or co-payments will be forwarded to our collection agency. However we are not responsible for following up with the insurance company to ensure that they provide reimbursement, this is the patient's responsibility.

Patients with insurance plans that require prior authorizations: **Prior authorization must be on file in writing prior to all scheduled appointments.** While our front office will attempt to obtain all authorizations prior to your appointment, it would be helpful and possibly expedite the process if you contact your referring party for insurance authorization.

By signing this form, you are certifying that you are eligible with the insurance company listed on the card you presented at the of your appointment. "I, the patient, understand that if the above is not true or if I am not eligible under the terms of my Medical and Subscriber Agreement, I am liable for any and all charges for services rendered.

No Show/Late Cancellation Policy: Patients who do not show up for a scheduled office appointment, or who do not cancel the appointment 24 hours in advance, will be charged a $100 fee. Any checks returned to us by the bank will be subject to a $25.00 fee.

A patient will be considered a cash patient once the account has been sent to collection due to a delinquent balance. *Any future services, after a patient has been sent to collections, will be paid at the time of service*. The patient will be responsible for any extraordinary costs associated with collection of funds owed to the practice, including but not limited to, collection agency fees, attorney's fees and court costs.

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3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our front office to arrange how to see your records.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our front office. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the front office.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our front office and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies please let the front office know.

I have read and understand the above Notice of Privacy Practice .

_____

Signature

_____

Date

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our front office staff about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

AUTHORIZATION FOR PAYMENT

Name of Patient:_____

Name of insurance company:_____

Subscribers name:_____ Subscribers Number:_____

Policy Number:_____ Group Number:_____

Phone Number:_____ Medicare Number:_____

Billing Address:_____

****

Secondary Insurance:_____

Subscribers Name:_____ Subscribers Number:_____

Policy Number:_____ Group Number:_____

Phone Number:_____

Billing Address:_____

****

I hereby authorize the named insurance company or companies for full payment to NBG, or any contracted or employed psychologist which may be directly under said corporation. I authorize full medical expense benefits allowable, and otherwise payable to you under my insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay in a current manner, any balance of said professional services charged over and above this insurance payment any co-pays, deductibles, or denied amounts.

Date:_____ Signature:_____

Assignment of benefits:

I hereby authorize NBG to furnish information to insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for psychological services rendered and all Major Medical Benefits. A copy shall be as valid as the original.

Date:_____ Signature:_____

I UNDERSTAND THAT ALL APPOINTMENTS MUST BE CANCELLED 24 HOURS IN ADVANCE. IF I DO NOT CANCEL WITHIN 24 HOURS, I WILL BE PERSONALLY CHARGED A LATE CANCELLATION FEE OF $80. FOR MISSED APPOINTMENTS, I WILL BE PERSONALLY CHARGED A NO SHOW FEE OF $100.

Date:_____ Signature:_____

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Patient Information

Name_____ SS#_____

Street Address_____

City_____State _____ Zip_____

Email Address_____

Date of Birth _____ Gender: M ___F ____

Marital Status: S M W Sep D Spouse's Name_____

Phone: Home_____ Office/Cell_____

Primary Care Physician_____ Phone:_____

May we contact your PCP? YES NO Referred By:_____

Emergency Contact_____

Relationship _____Phone:_____

Patient Employer Information

Employer's Name_____ Phone:_____

Employer's Address_____

City_____State/Zip_____

Patient's Occupation_____

Insured Person (If Not Patient)

Name_____ Phone:_____

Street Address_____ City/State_____ Zip_____

Subscriber's ID #_____Rel._____

Date of Birth_____SS#_____

Insurance

Primary Insurance Company _____

ID#_____ Group#_____ Phone:_____

Secondary Insurance Company Name_____

ID#_____ Group#_____ Phone:_____