

NEUROHEALTH ASSOCIATES

**Statement Of Patient Financial Responsibility for Neurohealth Associates**

Neurohealth Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment of any charges not covered by your insurer, payment of any deductibles, co-pays and co-insurances as determined by your contract with your insurance carrier.

**Neurohealth Associates will require a DOWN PAYMENT:** TO cover any portion of your deductible not met prior to services being rendered. Or a pay as go policy depending on your deductible amount until at which time your deductible is met.

**Commercial Insurance Carriers:** You are required to present a valid insurance card at every visit and as needed throughout your care. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of filing the claim, fees are due and payable in full from you. We understand that sometimes our patients may experience financial difficulties. If this should be the case, please communicate with our Financial Manager so that we may assist you in making payment arrangements. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered services will be due at the time services are rendered. A \$25.00 late fee will be incurred for any past due balances.

**Terms of Payment:** Payment is expected within 15 days of statement date. Any balances beyond 60 days will be referred to an outside collection agency. In the event that your account is turned over for collections then the patient or responsible party agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

**Medicare:** Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System) as well as secondary insurances that do not crossover. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered services will be due at the time services are rendered.

**Worker's Compensation:** If your visit is work-related we will need the case number and the carrier name, contact phone number, address and date of injury prior to your visit in order to bill the worker's compensation insurance company.

**Co-pay and Co-insurance Policy:** Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time of service at each visit. If your co-insurance is 50% we will require your co-insurance at the time services are rendered.

**Self-pay Policy:** In the event that I do not have health insurance, or that I know in advance that a specific service is not be covered by my insurance company, Or that NHA is not contracted and does not submit claims on my behalf, I will be responsible for payment prior to services rendered on the date of service at Neurohealth Associates. I agree to pay the full and entire amount at each visit. Neurohealth will assist to provide the information required to enable claims submission.

**Cancellation/No-show Policy:** We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, there will be a \$245 charge if you cancel or no show within 72 hours prior to your NEW PATIENT EVALUTION appointment. I will incur a fee of \$50.00 for each appointment missed, without notifying Neurohealth Associates 24 hours prior to my appointment time.

**Addendum Effective July 27<sup>th</sup> 2008:**We have recently instituted a \$80.00 technology surcharge/fee for the technology based portion of treatment (neurofeedback and biological feedback) which is due at the time of service, NO EXCEPTIONS. This is due to limitations imposed by insurance plans regarding such services. We appreciate your understanding. The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

**Updated 09/30/09** Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_

**PATIENT INFORMATION**

NAME:	FIRST	MIDDLE	LAST
<hr/>			
ADDRESS:			
<hr/>			
CITY:		STATE:	ZIP:
<hr/>			
DOB:	SSN:	SEX:	MARITAL STATUS:
<hr/>			
HOME:	CELL:	EMAIL:	
<hr/>			
EMPLOYER:	PHONE:		
<hr/>			
ADDRESS:			
<hr/>			
CITY:		STATE:	ZIP:
<hr/>			

**PARENT/SPOUSE INFORMATION**

NAME:	<hr/>		
<hr/>			
EMPLOYER:			PHONE:
<hr/>			
ADDRESS:			
<hr/>			
CITY:		STATE:	ZIP:
<hr/>			

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY:			
<hr/>			
SUBSCRIBER:		RELATIONSHIP:	DOB:
<hr/>			
ID NUMBER:	GROUP NUMBER:		
<hr/>			
EMPLOYER:	PHONE:		
<hr/>			
SECONDARY INSURANCE COMPANY:			
<hr/>			
SUBSCRIBER:		RELATIONSHIP:	DOB:
<hr/>			
ID NUMBER:	GROUP NUMBER:		
<hr/>			
EMPLOYER:	PHONE:		
<hr/>			

**EMERGENCY CONTACT**

NAME:	<hr/>		
	(not living with you)		
<hr/>			
ADDRESS:			
<hr/>			
CITY:		STATE:	ZIP:
<hr/>			

I, the undersigned, certify that information provided above is accurate to the best of my knowledge and that I assign the insurance benefits directly to Neurohealth Associates. I further understand that I am fully responsible for any and all financial balances resulting from insurance non-covered services, co-payments, and co-insurance. I authorize Neurohealth Associates to release my medical information to secure payments from the insurance. I authorize Neurohealth Associates to use the attached credit card information and my signature on file to secure remaining balances. I understand that it is my responsibility to provide contact information where I may be reached at all times as certain tests may require urgent attention.

<hr/>	<hr/>	<hr/>
RESPONSIBLE PARTY NAME	SIGNATURE	DATE



<b>Reading difficulties</b>	None	Mild	Moderate	Severe	
<b>Mathematical difficulties</b>	None	Mild	Moderate	Severe	
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<b>Emotional instability</b>	None	Mild	Moderate	Severe	
<b>Mood problems - sadness</b>	None	Mild	Moderate	Severe	
<b>Mood problem – anger</b>	None	Mild	Moderate	Severe	
<b>Aggression</b>	None	Mild	Moderate	Severe	
<b>Dark-violent thoughts</b>	None	Mild	Moderate	Severe	
<b>Mood problem – Irritability</b>	None	Mild	Moderate	Severe	
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<b>Negative – pessimistic thinking</b>	None	Mild	Moderate	Severe	10
<b>Difficulty “letting things go”</b>	None	Mild	Moderate	Severe	1
<b>Inability to “go with the flow”</b>	None	Mild	Moderate	Severe	△
<b>Moral preoccupations</b> (e.g., fixated on issues of right and wrong, fair and unfair, etc. )	None	Mild	Moderate	Severe	O-C
<b>Sensitivity to slights</b>	None	Mild	Moderate	Severe	
<b>Inability to feel empathy for others</b>	None	Mild	Moderate	Severe	
<b>Chronic Worrying</b>	None	Mild	Moderate	Severe	Fr/Phob:
<b>Anxiety – Nervousness</b>	None	Mild	Moderate	Severe	GAnx:
<b>Feeling like something bad is about to happen</b>	None	Mild	Moderate	Severe	Phys- Cog-
<b>Déjà vu</b>	None	Mild	Moderate	Severe	
<b>Unusual sensory perceptions</b> (e.g. seeing something out of the corner of his/her eye, hearing whispers when no one is around, etc.)	None	Mild	Moderate	Severe	
<b>Overly Self-Conscious</b>	None	Mild	Moderate	Severe	<b>For office use only:</b>

<b>Self Esteem problems</b>	None	Mild	Moderate	Severe	<p>H/N/V/GI/A</p> <p>A ___ V ___ T ___</p> <p>Slp-o – Slp-m</p> <p>Para-smns</p> <p><b>For office use only:</b></p>
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<b>Motor - Balance problems</b>	None	Mild	Moderate	Severe	
<b>Weakness</b> : Location: _____	None	Mild	Moderate	Severe	
<b>Increased Muscle Tension</b> (teeth grinding, nail biting, etc.)	None	Mild	Moderate	Severe	
<b>Urinary Control Problems</b>	None	Mild	Moderate	Severe	
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<b>Headaches</b>	None	Mild	Moderate	Severe	
<b>Chronic Pain</b> : Location _____	None	Mild	Moderate	Severe	
Location _____	None	Mild	Moderate	Severe	
<b>Abdominal-stomach discomfort</b>	None	Mild	Moderate	Severe	
<b>Appetite problems</b>	None	Mild	Moderate	Severe	
<b>Sensory (Sensitivity) Problems</b>	None	Mild	Moderate	Severe	
<b>Problems falling asleep</b>	None	Mild	Moderate	Severe	
<b>Problems staying asleep</b>	None	Mild	Moderate	Severe	
<b>Daytime energy problems</b>	None	Mild	Moderate	Severe	
<b>Motivation problems</b>	None	Mild	Moderate	Severe	
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<b>Social skills problems</b>	None	Mild	Moderate	Severe	
<b>Any developmental delays <u>when you were a child</u> in any of the following areas :</b>					
Speech _____	—	Language			
Motor-Balance-Coordination _____		:			
Social-interpersonal: _____					
Intellectual: _____					

**Incidents of mild or major head trauma (please list, including age)**

: \_\_\_\_\_  
\_\_\_\_\_

**Incidents of loss of consciousness (please list, including age):**

\_\_\_\_\_  
\_\_\_\_\_

**Stressful/Significant Life Events (e.g., loss of loved ones, injuries, accidents, relationship pain, etc.) ( please list, including age)**

\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Alcohol Overuse/Abuse History:** \_\_\_\_\_ No

\_\_\_\_\_ Yes

**Prescription Medication Overuse/Abuse History:** \_\_\_\_\_ No

\_\_\_\_\_ Yes

**Recreational Drugs Overuse/Abuse History:** \_\_\_\_\_ No

\_\_\_\_\_ Yes

**Cigarette Smoking:** \_\_\_\_\_ No

	<b>For office use only:</b>
_____ Yes	
<b>Medications</b> (including dosage) _____ _____ _____ _____ _____ _____ _____	
<b>BIOLOGICAL MOTHER</b> If Living, Please list current age: _____ If Deceased, Please list age at death: _____ <b>Mother's Medical History:</b> _____ _____	
<b>Mother's Psychological History</b> (depression, bipolar, alcoholism, anxiety, etc.) _____	
<b>BIOLOGICAL FATHER</b> If Living, Please list current age: _____ If Deceased, Please list age at death: _____ <b>Father's Medical History:</b> _____ _____	
<b>Psychological History</b> (depression, bipolar, alcoholism, anxiety, etc.) _____	
<b>Medical History of Biological brother(s)/sister(s), if applicable:</b> _____	

**For office use only:**

\_\_\_\_\_

**Have you had any previous Brain MRI, CT, fMRI, Brain Maps, or EEGs? Yes No**

Date/Findings: \_\_\_\_\_

**Previous Treatment(s) for the current symptom (please describe):**

\_\_\_\_\_

**Typically, statistical analysis/interpretation of today's results and report generation require 7-14 days to complete. Testing is either completed in 1 or 2 appointments, depending on the evaluation conducted.**

**In addition to the referral source (if applicable), who would you like a copy of the report sent to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**\* PLEASE COMPLETE THE AUTHORIZATION FORM ATTACHED**

I acknowledge that Neurohealth Associates may periodically send me Newsletters, new technology updates and special offers via the e-mail address provided below.

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Signature \_\_\_\_\_

No I do not wish to receive emails.

(A) Notifier(s): Neurohealth Associates 477 E. Butterfield Rd Lombard IL 60148  
 (B) Patient Name: \_\_\_\_\_ (C) Identification Number: \_\_\_\_\_

**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

**NOTE:** If Medicare doesn't pay for (D) 90901, 95957, 96118, 96119, 90832, 90834, 90837 below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) Services below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
90901 Neurofeedback 95957 Brainmap 96118 and 96119 Testing	Not a Medicare Covered Service Not a Medicare Covered Service You do Not have a Referral	\$80.00 \$495.00 \$1700.00
<b>Psychotherapy</b>  90832, 90834, 90837  96118/96119 Testing	Medicare Takes an ADDITIONAL Reduction in Benefits For Mental Health Benefits (Member Responsible) Medicare Takes an ADDITIONAL Reduction in Benefits For Mental Health Benefits (Member Responsible) Medicare Takes an ADDITIONAL Reduction in Benefits For Mental Health Benefits (Member Responsible)	55% Coins.  55% Coins  55% Coins

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) Services listed above.  
 Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**(G) OPTIONS:** Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

**OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**(H) Additional Information:**  
 This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature: \_\_\_\_\_ (J) Date: \_\_\_\_\_

**Authorization for Release of Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

I authorize the NHA to release information to:

I authorize the NHA to obtain information from:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone #/Fax # (Include area code)

\_\_\_\_\_  
Phone #/Fax # (Include area code)

**PURPOSE OF THIS REQUEST:** (check one)  **Healthcare**  **Insurance Coverage**  **Personal**  **Other**

**TYPE OF RECORDS AUTHORIZED:**  Psychiatric/Psychological/Educational Evaluation and/or Treatment  
 Medical

**SPECIFIC INFORMATION AUTHORIZED:** (select one or more as appropriate)

- Assessments  **Progress Notes**  Laboratory Test Results: \_\_\_\_\_
- Diagnostic Impression  **Discharge Summary**  Treatment Plans
- Treatment Summary
- Other: (please describe) \_\_\_\_\_

**One-time Use/Disclosure:** I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

- When the requested information has been sent/received.
- 90 days from this date.  Other: \_\_\_\_\_

**Periodic Use/Disclosure:** I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. **My authorization will expire:**

- When I am no longer receiving services from the Neurohealth Associates.
- One year from this date.  Other: \_\_\_\_\_

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to the NHA, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

**Signature of Patient or Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_