Neurohealth Associates
Center for Neurofeedback

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.

Addendum Effective July 27th 2008: We have recently instituted a $85.00 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 limitiations 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.

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.

Updated 02/18/14 Signature _____ Date_____

Printed Name: _____

Neurohealth Associates
Center for Neurofeedback

PATIENT INFORMATION

NAME: FIRST MIDDLE LAST

_____

ADDRESS:_____

CITY: _____STATE : _____ZIP :_____

DOB: _____SSN: _____SEX:_____ MARITAL STATUS_____

HOME: _____ CELL: _____EMAIL: _____

EMPLOYER: _____PHONE: _____

ADDRESS:_____

CITY: _____STATE : _____ZIP :_____

PARENT/ SPOUSE INFORMATION

NAME:_____

EMPLOYER: _____PHONE: _____

ADDRESS:_____

CITY: _____STATE : _____ZIP :_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

SUBSCRIBER: _____RELATIONSHIP: _____DOB: _____

ID NUMBER:_____GROUP NUMBER:_____

EMPLOYER: _____PHONE: _____

SECONDARY INSURANCE COMPANY:_____

SUBSCRIBER: _____RELATIONSHIP: _____DOB: _____

ID NUMBER:_____GROUP NUMBER:_____

EMPLOYER: _____ PHONE: _____

EMERGENCY CONTACT

NAME:_____(not living with you)

ADDRESS:_____

CITY: _____STATE : _____ZIP :_____

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.

RESPONSIBLE PARTY NAME: _____STATE : _____ZIP :_____

Neurohealth Associates

First Name: Last Name:

Handedness: R L Grade:

How were you referred to Neurohealth Associates? (If applicable):

☐ Check this box if the above mentioned referral source is the child's provider and you authorize us to communicate your child's results/treatment plan to this provider

Child's Pediatrician:

☐ Check this box if you authorize us to communicate your child's results/treatment plan to this provider

Other clinicians/therapists/doctors involved in your child's care (If applicable):

☐ Check this box if you authorize us to communicate your child's results/treatment plan to this provider

PLEASE SIGN BELOW:

Signature: _____

Printed name: _____

Neurohealth Associates

Please provide a brief summary of the main symptoms and/or areas of needed improvement:

Past Medication(s) (as applicable):

Name	Dosage

Current Medication(s) (as applicable):

Name	Dosage

Neurohealth Associates
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Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

Patient ID#: _____ **Phone Number:** _____

☐ **I authorize the NHA to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

☐ **I authorize the NHA to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip 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** ☐ **Appointment Information** ☐ **Scheduling/Modifying Appointments**

☐ **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: _____

Relationship to Patient (*if requester is not the patient*): ☐ Parent ☐ Legal Guardian ☐ Other: _____

Patient or Representative has been provided a copy of this authorization:

_____
Staff member providing copy

Revised 8/19/08

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.

Understanding Your mental Health Record Information

Each time that you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medical education.
- Source of information for public health officials charged with improving the health of the regions that they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health record and how your health information is used helps you to—

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. “Health care operations” consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or

disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), § 164.510(a) (for facility directories, but note that you have the right to object to such uses), or § 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

- Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
    - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
    - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
    - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.
    - Information that is copyright protected, such as certain raw data obtained from testing.

  In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:
    - A licensed health care professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
    - PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional

judgment, that the access is reasonably likely to cause substantial harm to such other person.
    - The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

  For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
    - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
    - The records are not available to you as discussed immediately above.
    - The record is accurate and complete.

  If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.
- Obtain an accounting of nonroutine uses and disclosures, those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosures for treatment, payment, and health care operations under certain circumstances, primarily if we maintain an electronic health record. We do not need to provide an accounting for the following disclosures:
    - To you for disclosures of protected health information ("PHI") to you.
    - For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care of your location, general condition, or death).
    - For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
    - To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
    - That occurred before April 14, 2003.

We must provide the accounting within 60 days. The accounting must include the following information:
    - Date of each disclosure.
    - Name and address of the organization or person who received the protected health information.
    - Brief description of the information disclosed.
    - Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

  The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.
- Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law. These include most uses or disclosures of psychotherapy notes, marketing communications, and sales of PHI. Other uses and disclosures *not described in this notice* will be made only with your written authorization.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

- **We may use your health information for treatment.**
  Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions that they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide your physician, other health care professionals, or a subsequent health care provider copies of your records to assist them in treating you once we are no longer treating you. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

- **We may use your health information for payment.**
  Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

- **We may use your health information for health care operations.**
  Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

- **Business associates.**
  We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010, business associates must comply with the same federal security and privacy rules as we do.

- **Notification.**
  We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition.

- **Communication with family.**
  Unless you object, we, as health professionals, using our best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.

- **Research.**
  We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- **Funeral directors.**
  We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

- **Marketing/continuity of care.**
  We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If we contact you to provide marketing information for other products or services, you have the right to opt out of receiving such communications. Contact the Rosy at 630-969-3233.

Workers compensation.
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

- **Public health.**
  As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- **Correctional institution.**
  If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

- **Law enforcement.**
  We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

- **Health oversight agencies and public health authorities.**
  If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the Department of health.

- **The federal Department of Health and Human Services ("DHHS").**
  Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

Effective date: September 2013

Signature: _____

Printed name: _____