NEUROHEALTH
CENTER FOR NEUROFEEDBACK
Empowering the Mind

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: T0 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 $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 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: _____

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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 :_____

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NEUROHEALTH ASSOCIATES PEDIATRIC HEALTH HISTORY FORM

Child's Name: _____

Birthdate: _____ Age: _____

Child's Pediatrician: _____

Address: _____

Phone: _____

Other Doctors/Therapists: _____

_____

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

Name:_____

Address _____

Name:_____

Address _____

******COMPLETE RELEASE FORM ATTACHED******

How did you find out about NeuroHealth Associates?

_____

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

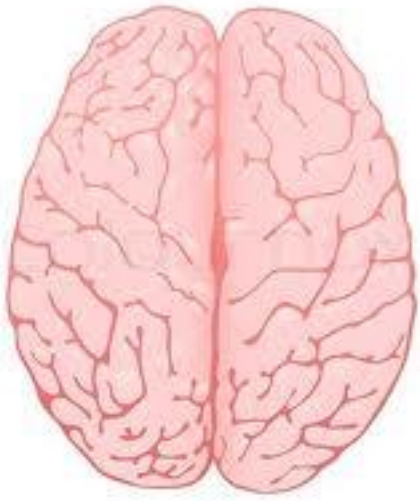
Name:_____

Email:_____

Signature_____

☐ No I do not wish to receive emails.

For office use only:



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Present Health/Behavioral/Cognitive Concerns: please describe.

_____

_____

_____

Please rate level of severity regarding areas of concern:

Attention problems	None	Mild	Moderate	Severe
Difficulty holding information in mind	None	Mild	Moderate	Severe
Memory problems	None	Mild	Moderate	Severe
Organizational problems	None	Mild	Moderate	Severe
Initiation – "Self starting" Problems	None	Mild	Moderate	Severe
Impulse Control problems	None	Mild	Moderate	Severe
Inability to learn from experience	None	Mild	Moderate	Severe

What grade is your child in? _____Please circle typical/current grades in the following areas (if applicable):

English - Language Arts	A	B	C	D	F
Reading	A	B	C	D	F
Mathematics	A	B	C	D	F
Science	A	B	C	D	F
Social Studies	A	B	C	D	F

Difficulties remembering to turn in assignments	None	Mild	Moderate	Severe
Language expression problems	None	Mild	Moderate	Severe
Writing difficulties	None	Mild	Moderate	Severe
Reading difficulties	None	Mild	Moderate	Severe
Mathematical difficulties	None	Mild	Moderate	Severe

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Emotional instability	None	Mild	Moderate	Severe
Mood problems – sadness	None	Mild	Moderate	Severe
Mood problem – anger	None	Mild	Moderate	Severe
Mood problem – Irritability	None	Mild	Moderate	Severe
Negative thinking-pessimism	None	Mild	Moderate	Severe
Difficulty "letting things go"	None	Mild	Moderate	Severe
Inability to "go with the flow"	None	Mild	Moderate	Severe
Moral preoccupations (e.g., fixated on issues of right and wrong, fair and unfair, etc.)	None	Mild	Moderate	Severe
Chronic Worrying	None	Mild	Moderate	Severe
Anxiety – Nervousness	None	Mild	Moderate	Severe
Tendency to predict the worst	None	Mild	Moderate	Severe
Déjà vu	None	Mild	Moderate	Severe
Unusual sensory perceptions (e.g. seeing something out of the corner of his/her eye, hearing whispers when no one is around, etc.)	None	Mild	Moderate	Severe
Odd or "different" thinking	None	Mild	Moderate	Severe
Behavioral problems	None	Mild	Moderate	Severe
Oppositional-Defiant	None	Mild	Moderate	Severe
Verbal or Physical Aggression	None	Mild	Moderate	Severe
Dark-violent thoughts	None	Mild	Moderate	Severe
Inability to feel empathy for others	None	Mild	Moderate	Severe
Sensitivity to slights	None	Mild	Moderate	Severe
Overly Self-Conscious	None	Mild	Moderate	Severe
Self Esteem problems	None	Mild	Moderate	Severe

Hyperactivity-Motor Problems	None	Mild	Moderate	Severe

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Tics-repetitive movements	None	Mild	Moderate	Severe
Fine motor problems	None	Mild	Moderate	Severe
Balance or Coordination Problems	None	Mild	Moderate	Severe
Teeth Grinding at night	None	Mild	Moderate	Severe
Nail Biting during day	None	Mild	Moderate	Severe

Headaches	None	Mild	Moderate	Severe
Abdominal-stomach discomfort	None	Mild	Moderate	Severe
Appetite problems	None	Mild	Moderate	Severe
Sensory (Sensitivity) Problems	None	Mild	Moderate	Severe
Sleep problems	None	Mild	Moderate	Severe
Bed Wetting Problems	None	Mild	Moderate	Severe
Energy problems	None	Mild	Moderate	Severe
Motivation problems	None	Mild	Moderate	Severe
Social skills problems	None	Mild	Moderate	Severe
Lack of social intuition	None	Mild	Moderate	Severe
Difficulty recognizing facial expressions	None	Mild	Moderate	Severe
Difficulty decoding voice intonation	None	Mild	Moderate	Severe
Eye contact problems	None	Mild	Moderate	Severe

Is your child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other

Was he/she born: ☐ Full term ☐ pare-term

Please indicate any problem(s) during pregnancy:

_____

Delivery by: ☐ Vaginal birth ☐ Caesarean

Birth Weight: _____ APGAR scores

H/N/V/GI/A

A ___V___T___
Slp-o – Slp-m

Para-smns NM NT SW

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Any developmental delays in :

- ☐ Toilet Training_____
- ☐ 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, bullying, parental separation, etc.)
(please list, including age)

_____

_____

Previous Treatment(s) (please circle): Behavior Therapy Counseling
Neurofeedback Medication Occupational Therapy Physical Therapy
Speech Therapy Tutoring Nutritional Other: _____

Past Medical History:

_____

_____

Medications: Past:

_____

Current: _____

What grade is your child in currently? _____

Does your child receive an Individualized Educational Plan (IEP) or 504 plan through his/her school district? If so, please list date implemented and problems identified.

_____

_____

If your child is younger and does not receive letter grades, please
describe his/her school performance thus far (e.g., teacher's comments, etc.)

_____

_____

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With whom does your child live (including siblings, if applicable)?

_____

Biological Mother, years of education: _____

Occupation (if applicable) _____

Medical History: _____

Rate quality of relationship between mother (or primary female figure in child's life) and child (please circle):

poor fair-good good excellent

Biological Father, years of education: _____

Occupation (if applicable) _____

Medical History: _____

Rate quality of relationship between father (or primary male figure in

child's life) and child (please circle):

poor fair-good good excellent

Medical History of Biological brother(s)/sister(s), if applicable:

_____

Rate quality of relationship between child and sibling(s), if applicable: (please circle):

poor fair-good good excellent

Has Neuropsychological-Cognitive Testing previously been conducted? Yes No Date/Findings: _____

Have any previous Brain MRI, CT, fMRI, Brain Maps, or EEGs been conducted? Yes No Date/Findings: _____

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Typically, statistical analysis/interpretation of today's results and report generation require 10-14 days to complete. Testing is either completed in 1 or 2 appointments, depending on the evaluation conducted.

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Individualized "Parent-Child Interaction" Strategy Development

Are you interested in learning more about strategies that may be helpful in managing your child's dysregulated behavior?

Yes, tell me more ____ Not sure_____
No, I'm not interested and/or not applicable _____

Individualized Education Planning (IEP) and 504 Planning

Are you interested in learning more about specialized psychoeducational consultation that can be conducted, via formal meeting with school officials, by a NeuroHealth Associates neuropsychologist?

This service typically includes, one or all, of the following:

- Review of results with the child's educational team for developmental of accommodations and strategies for enhancing the child's educational experience.
- Identify areas of strength and weakness, based on objective neurocognitive test results, so that curriculum/tutoring, etc. can be specifically individualized to the child's needs.
- Individualized Educational Planning and 504 Plan development, and determination of appropriate and necessary services.

Yes, tell me more ____ Not sure_____No,/or not applicable _____

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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