

NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE 09/18/2006

This summary of our Notice of Privacy practices informs you of how we may use or disclose your health information. It also explains your rights and our duties under the current privacy laws.

OUR RIGHTS: We may use and disclose your health information to;

- Provide patient care and treatment and for the operation of our healthcare practice;
- Process claims/billing to your health plan, insurance company, or third party;
- Comply with laws that require reporting of your health information;
- Review your records for quality of care;
- Remind you of appointments;
- Inform you of any health services or benefit that may interest you;
- Use for research purposes;
- Use for organ and tissue donation if you are an organ donor;
- Use as may be required by law;
- Avert a serious threat to health or safety;

YOUR RIGHTS: While the records we maintain about you belong to us, you have a number of rights with respect to those records. You have the right to:

- Request a copy of our full privacy notice;
- See your record and request a copy;
- Request we amend your record if you believe it is not complete or correct;
- Request we send information to you in a confidential manner;
- Request a restriction or limitation on the health information we use or disclose about you;
- Complain to us and/or the US Department of Health and Human Services if you believe we have violated your privacy rights;
- Request a list of any disclosures not required for treatment, payment and business operations for a period of up to six years.

OUR DUTIES: We must provide you with our Notice of Privacy Practices and abide by its terms. We may:

- Charge a fee for copies of your medical information;
- Require up to 60 to 90 days to process your request for records;
- Deny your request to amend your records for certain reasons and if asked, give you a written reason;
- Amend the Notice from time to time, post the revised notice, and make a copy for you upon request.

If you have any questions, Please contact our Business Manager at 630-969-3233.

Acknowledgements of receipt of this notice. We will request that you sign this form acknowledging that you have received a copy of this notice if desired. If you choose, or are not able to sign, a staff member will sign his or her name and date. This acknowledgment will be filed with your records

Signature

Print Name

Date

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 \$20.00 for each appointment missed, without notifying Neurohealth Associates 24 hours prior to my appointment time.

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 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
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	SIGNATURE	DATE
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NEUROHEALTH ASSOCIATES PEDIATRIC HEALTH HISTORY FORM

Child's Name: _____
 Birthdate: _____ Age: _____
 Child's Pediatrician: _____
 Address: _____
 Phone: _____
 Other Doctors/Therapists: _____

Are you self referred? _____ or referred by a healthcare
 provider? _____

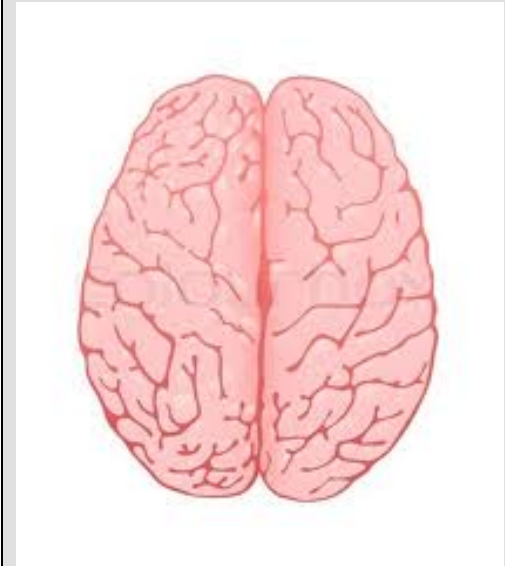
How did you find out about NeuroHealth Associates?

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"	None	Mild	Moderate	Severe
problems				
Impulse Control problems	None	Mild	Moderate	Severe

For office use only:



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Epis Mem
 Mat Temp

	None	Mild	Moderate	Severe	
Inability to learn from experience					
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	

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	

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GAnx:

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.):

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

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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: _____

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.

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

Name: _____ Address: _____

Name: _____ Address: _____

For office use only:

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

**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 psycho-educational 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.**
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Yes, tell me more _____ Not sure _____

No, I’m not interested and/or not applicable _____

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 _____

or

No I do not wish to receive emails.

For office use only:

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:

I authorize the NHA to obtain information from:

Name of Provider or Facility

Address

City, State, Zip Code

Phone #/Fax # (Include area code)

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