Carolina Neuropsychological Service, Inc.

Neuropsychology & Rehabilitation Psychology
1540 Sunday Drive, Suite 200, Raleigh, NC 27607
Office: 919-859-9040, FAX: 919-859-9030
www.CarolinaCNS.com

Name:____________________ Date Examined:____________________

Responsible Person: ____________________ Birth Date:____________________

Address:____

Age:____ Sex: M____ F____ Marital Status: S____ M____ D____ W____ SSN:____________________

Home Phone:__________________ Work Phone:__________________ Cell Phone: __________________

Email Address:____________________ Educational Years:____________________

Employer:____________________ Occupation:____________________

Physician Name & Address:____

Referred By: ____________________ Phone:____________________

Reason(s) For Referral: ____

____

Current medications: ____

____

Is injury/illness work related? _____YES _____NO Date of injury/illness: ____/______/______

Type of Visit: _____Illness _____Accident _____Auto Accident_____Other:____________________

Are you involved in a lawsuit? ____YES _____NO

Attorney's name & phone number____

Insured Party: ____

Date of Birth of Insured: ______________ SSN: ____________________

Employer: ____

Insurance Company: ____

Insured ID: ____________________Group number: ____________________

Person responsible for payment: ____________________ ____________________

Mailing Address: ____

AUTHORIZATION: I have read the attached Business Policy and understand its terms. I give Dr. Conder and his associates permission to provide treatment and assessment services as needed, and to process insurance claims with assignment of benefits made directly to CNS.

SIGNED:____________________ DATE:____________________

RELATIONSHIP TO PATIENT:____________________

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BUSINESS POLICY

The following information is prepared as a guide to the policies and procedures of **Carolina Neuropsychological Service, Inc.** Please review it carefully. If there are any questions or concerns, please feel free to discuss them with your doctor, or with the Office Manager.

Informed Consent:

I acknowledge that I am voluntarily seeking a neurocognitive evaluation and/or treatment, even though I may have been referred by my doctor or other parties. I understand that the information obtained in the evaluation and/or treatment is confidential, and will be released to other parties only with my written permission. There are exceptions to confidentiality. These exceptions are Workman's Compensation cases, Court-ordered release of information, participation in a civil or criminal lawsuits, allegations or admissions of child or disabled persons abuse or neglect, or potential danger to self or others.

Fee Schedule and Billing Policies:

This practice will bill your insurance carrier for you, at no cost for filing the insurance forms. All deductibles or co-payments are to be paid at the time of the visit. Any charges not paid by the insurance carrier are the patient's responsibility. Sometimes the insurance carrier will not honor our charges. However, our charges are consistent with national averages for this type of service and any charges not paid by the insurance carrier are the patient's responsibility. Additionally, if an insurance carrier retrospectively denies charges, and requests return of payment, those payments will be due from the patient.

Payment is due at the time of service and past due in 30 days from the date of receipt. A 1.5% monthly service charge (18% yearly) may be added to past due accounts. Seeing that an account is paid is your responsibility. This office will help provide information to your insurance company. However, we cannot accept the responsibility of negotiating settlements on disputed insurance claims. That is your responsibility. If Carolina Neuropsychological Service bills your insurance company, but they mistakenly pay you, checks should be sent immediately to our office.

Medicare:

The major exception to the above involves Medicare. For Medicare patients, we bill at the allowable rate set by the federal government for these services, as we are a Medicare participating provider. Any deductibles or co-payments are the patient's responsibility. Evaluation procedures are paid at 80% by Medicare, and are considered Medical procedures. Psychotherapy and other procedures are paid at 50%. The remaining balance is the patient's responsibility, either through a secondary Medicare carrier or a co-payment, or both.

HMOs/PPOs:

The other exception has to do with fees set by HMOs/PPOs for which we are a participating provider. Prior to your first visit, your HMO/PPO must authorize your visit and provide this office and you with the proper forms and the authorization number. Almost all HMOs are unwilling to authorize or reimburse a service after it has taken place. In the event that no authorization is available, you will be responsible for the full charge. You will also be responsible for the required co-payment for each session. Please note that most HMOs/PPOs require a co-payment per unit of service for neuropsychological or neurocognitive testing. That is, the HMO/PPO does not count the entire testing session as one visit, but requires a co-payment for each unit (hour) of testing. It will be your responsibility to have this authorization renewed as necessary. We will provide you with as much assistance as possible in obtaining initial or re-authorization.

Late Cancellations or Missed Appointments:

Appointments missed without a 24-hour notice or not due to a true emergency may be billed a missed appointment fee, depending on the type of service scheduled. Insurance does not cover this. Many HMOs allow patients to be billed directly for missed appointments.

PLEASE TURN OVER AND SIGN ON THE BACK

Custody Situations:

If a child is seen at the request of a non-custodial parent, the parent signing the business contract will be responsible for payment of all fees, unless the custodial parent signs the business contract.

Collections:

Payment is due at the time of service, and considered past due in 30 days. We do not like to turn accounts over to our collection agency or go to Small Claims Court, but we will. Please note that accounts going to a Collection Agency may result in a person's permanent credit record being marred, which will be noted any time a person applies for a loan such as a house or car loan, credit cards, or other accounts. For non-payment of one's bill, confidentiality will be maintained by only providing/releasing information necessary to process a claim by a collection agency or Small Claims Court. We do not negotiate payment plans in-house. We do take almost all credit cards. Credit Cards or other outside financial arrangements must be made, as necessary.

Legal/Forensic Services:

Medical Insurance will not reimburse services which are Court Ordered or are instigated primarily for a legal process, including personal injury suits, and which are deemed not medically necessary. For Legal proceedings, there are non-medical questions and procedures which will be addressed. As such, Insurance will not be billed. Payment for such Legal/Forensic services should be paid in advance. Please request other forms for Forensic Services.

Educational Testing and other Educational Services:

Please note that Insurance companies do not consider testing which is primarily Educational in nature as “medically necessary” and will not reimburse these services. This would include Learning Disability determination, as well as Foreign Language exemption assessment. Further, our attendance at Patient Educational Conferences, including IEPs, is not covered by insurance. For these activities, attendance at requisite conferences, as well as preparation time (records review and telephonic conferences with teachers/counselors), and travel time to and from conferences is billable time, but is not covered by insurance companies. Charges for these activities are directly billable to the parent or other responsible person. Payment should be made in advance.

Internet Services:

Please note that while we have Internet services for providing practice information and downloading Registration forms, any communications over the Internet can not be considered Confidential. Additionally, we will try to respond to brief messages. However, extensive Internet communications regarding consultation and/or treatment issues will be considered a billable service, as noted by the AMA CPT panel. However, most insurance companies will not reimburse these services. As such, they will be billed directly to the patient or responsible person.

Other Policies:

During the course of treatment it may be necessary to compensate for rising costs and inflation. Fees and Policies will be reviewed periodically, as adjusted as necessary.

Messages & Emergencies:

For all messages call 919-859-9040. If the secretary is not available, leave a message on the voice mail. Please leave a message with several phone numbers where you can be reached. **In the event of a life-threatening emergency, call 911, your primary care physician, or go to an emergency room.**

By signing this registration page, I acknowledge Informed Consent has been given and received, and I am in agreement with these policies and procedures.

Signed:____**Date:** ____________

Relation to Patient: ____

Witness:____

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RELEASE OF INFORMATION

TO ENSURE CONTINUITY OF CARE, WE NEED TO PROVIDE REPORTS OR OTHER INFORMATION TO YOUR OTHER HEALTH CARE PROVIDERS

I, ______________________________, give Carolina Neuropsychological Service, Inc. (doctors and administrative staff) permission to release and/or exchange the following protected information from my clinical record about my evaluation and/or treatment:

_______ Neuropsychological Evaluations
_______ Psychological Evaluations
______ Verbal Communications (Personal and Telephonic)
______ Billing Information
______ General Summaries
_______ Any and all of the above
_______ Psychotherapy notes or Summaries (If you wish to release these, please request a separate form)

_______ ____

This information should be sent to (name, address, and phone number):

1) ____
2) ____
3) ____

Three copies of your report will be distributed at no charge

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information, as well as specifying the situations under which exceptions to confidentiality may occur.

This authorization to release information from my records and for verbal communications is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that I may revoke this consent (in writing) at any time up to the extent that action based on this release has been taken by sending a written request to our office. However, your revocation will not be effective to the extent that CNS has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim. I understand that CNS generally may not condition service provision upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer protected by the HIPAA Privacy Rule. This consent will expire automatically one year from the date on which it is signed below (***). Earlier termination of this Release can be specified in writing to CNS.

______________________________	______________________________
Signature	Patient's Date of Birth
______________________________	______________________________
Witness	(***) Today's Date

-If you are a legal representative of the patient (parent or legal guardian), please indicate your authority to sign and act for the patient.

A photocopy of this consent shall be considered as effective and valid as the original.

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REQUEST FOR INFORMATION

TO PROVIDE THE BEST TREATMENT FOR YOU, WE NEED TO REVIEW INFORMATION FROM YOUR OTHER HEALTH CARE PROVIDERS

I, ______________________________, request that the following information be released to:
(PRINT FULL NAME)

Carolina Neuropsychological Service

_____ History & Physical
_____ Psychological Testing
_____ Neuropsychological Testing
_____ Discharge Summaries
_____ School Records
_____ Reports of CT/MRI/EEG
_____ Therapy Summaries
_____ Labs
_____ Work Performance Evaluations
_____ Military Records
_____ Verbal Communications
____
____

The purpose for the release of this data shall be for professional services only.

This authorization and request to obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part.

I understand that I may revoke this consent in writing at any time except to the extent that action based on this release has been taken. This consent will expire automatically one year from the date on which it is signed below. Earlier revocation must be received in writing.

______________________________ ______________________________
Signature Patient's Date of Birth

______________________________ ______________________________
Witness Today's Date

- If you are a legal representative of the patient (parent or legal guardian), please indicate your authority to sign and act for the patient.

______________________________ ______________________________

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT FORM

This form, when completed by you, acknowledges that you have received a copy of the Notice of Privacy Practices for Carolina Neuropsychological Service, Inc.

I, ______________________________ , acknowledge that I have received a copy of the Notice of Privacy
(Print Patient's Name Above)   Practices for Carolina Neuropsychological Service, Inc.

on this date ____________________ 20____.

____
Signature of Patient or Personal Representative

If the acknowledgement is signed by a personal representative of the patient, the name of the patient and a description of such representative's authority to act for the patient must be provided below:

Patient's name:____

Authority to act for patient: ____________________________________
(Example - parent or legal guardian)

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Request for Confidential Handling of Health Information By Alternative Means

I, ____ request that
(Print First and Last Name of patient/recipient)

Carolina Neuropsychological Service, Inc handle my confidential health information with regards to usual office communications. This means that we may contact you or send you health care or billing information in the following ways: direct mail; fax; telephone calls either to home or business, or email. Mail and telephone calls will go to your regular address and phone numbers you have provided.

IF YOU AGREE WITH THIS, YOU DO NOT NEED TO COMPLETE THE INFORMATION BELOW.

STOP HERE AND SIGN.

____ **Date:** _________________________

A. However, if you wish to receive mail at a different address, specify below:

____
(Street Address)
____
(City) (State) (Zip Code)

B. If you wish to be contacted by telephone at a different phone number, or do not wish to be contacted at your usual home and/or business number, specify below the number(s) you need to be contacted at:

____

C. If you wish to be contacted by an alternate means, such as fax or email, specify the correct phone number or mail address below:

____
____

All reasonable requests to receive communication of your health information by alternative means will be granted.

____ ____________________
(Signature) (Date)

SIGN THIS *ONLY* IF YOU WANT HEALTH INFORMATION SENT TO AN ALTERNATIVE ADDRESS OR BY AN ALTERNATIVE MEANS. Otherwise will send your information by US Mail, Fax and/or telephone as our usual means.

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NORTH CAROLINA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Carolina Neuropsych Service (CNS) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when CNS provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when CNS consults with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when CNS obtains reimbursement for your healthcare. Examples of payment are when CNS discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of CNS. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within CNS such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of CNS, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

CNS may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when CNS is asked for information for purposes outside of treatment, payment and health care operations, CNS will obtain an authorization from you before releasing this information. CNS will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes CNS has made about our conversation during a private, group, joint, or family counseling session, which CNS has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) CNS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

CNS may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If you give CNS information, which leads CNS to suspect child abuse, neglect, or death due to maltreatment, CNS must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, CNS must do so.

- **Disabled Abuse:** If information you give CNS gives us reasonable cause to believe that a disabled adult is in need of protective services, CNS must report this to the Director of Social Services.

- **Health Oversight:** The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should any persons at CNS be the focus of an inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about the professional services that CNS has provided you and/or the records thereof, such information is privileged under state law, and CNS must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. “Raw data” that is developed in reasonable expectation of a civil, criminal or forensic proceeding is exempt from release to you or your representative, unless CNS is given a valid court order by a judge.(45 CFR 45 164.508 & 164.524[(a)][(1)]).

- **Serious Threat to Health or Safety:** CNS may disclose your confidential information to protect you or others from a serious threat of harm by you.

- **Worker’s Compensation:** If you file a workers’ compensation claim or are seen as part of a worker’s compensation claim, CNS is required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

IV. Patient's Rights and Psychologist's Duties

Patient’s Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, CNS is not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are receiving services at CNS. Upon your request, CNS will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. CNS may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, CNS will discuss with you the details of the request and denial process. This does not pertain to “psychotherapy notes” or Raw data” that is developed in reasonable expectation of a civil, criminal or forensic proceeding is exempt from release to you or your representative, unless CNS is given a valid court order by a judge; or if material was released to us on the grounds that it not be redisclosed.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. CNS may deny your request. On your request, CNS will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, CNS will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from CNS upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- CNS is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- CNS reserves the right to change the privacy policies and practices described in this notice. Unless CNS notifies you of such changes, however, we are required to abide by the terms currently in effect.
- If CNS revises our policies and procedures, CNS will publicly post such changes on the bulletin board in the waiting room.

V. Complaints

If you are concerned that CNS has violated your privacy rights, or you disagree with a decision CNS has made about access to your records, you may contact Dr. Robert Conder at 919-859-9040 and request a Privacy Complaint form.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

CNS reserves the right to change the terms of this notice and to make the new provisions effective for all PHI that we maintain. CNS will provide you with a revised notice by a pubic posting on the bulletin board in the waiting room.