NEUROPSYCHOLOGY ASSOCIATES, P.A. Chart#:_____

PATIENT INFORMATION:

Last Name:_____Maiden Name:_____First Name:_____M.I. ____

Address:_____
Street City State Zip County

Home Phone#: _____Work Phone#: _____ Cell Phone#: _____

Email address: _____

(Circle one) Sex: **M F** (circle one) **Marital Status**: **S M W D** Spouse's Name: _____

Patient's Social Security#: _____ Patient's Date of Birth: _____

Referring Doctor: _____

Primary Care Physician: _____

PERSON RESPONSIBLE FOR BILL:

Guarantor's Last Name: _____ Guarantor's First Name: _____

Relationship to Patient: _____ Social Security#: _____ Date of Birth: _____

Address: _____
Street City State Zip County

Home Phone#: _____ Work Phone#: _____ Other#: _____

Employer Name: _____ Address: _____

INSURANCE INFORMATION:

1st Insurance: _____ Policy Holder/Subscriber's Name: _____
Policy#: _____ Group#: _____
2nd Insurance: _____ Policy Holder/Subscriber's Name: _____
Policy#: _____ Group#: _____

MEDICARE PATIENTS PLEASE READ AND SIGN

Medicare #: _____ Supplemental Insurance: _____
Policy #: _____ Address: _____
Are you or your spouse currently working? Yes No If yes, is Medicare Primary? Yes No
I request payment of authorized Medigap benefits be made on my behalf to Neuropsychological Associates for services furnished to me by them. I authorize any holder of medical information about me to release to:_____ (Medigap Insurer). Any information needed to determine these benefits on the benefits payable for related services.
Patient's Signature: _____ Date: _____

WORKERS COMPENSATION: _____ Date of Injury: _____
Name of Insurance Carrier: _____ Claim#: _____
Address: _____ Phone#: _____
Street City State Zip

IF ACCIDENT RELATED:

Name of Responsible Ins. Co. _____ Phone#: _____
Address: _____ Date of Injury: _____
Policy Holder Name: _____ Policy#: _____

IMPORTANT INFORMATION…READ CAREFULLY

1. I authorize NEUROPSYCHOLOGY ASSOCIATES, P.A. to release medical and other information concerning this of related claims to government agencies including Social Security Administration and its intermediaries, insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize NEUROPSYCHOLOGICAL ASSOCIATES, P.A. to release medical records and billing information to my primary care and referring physician.
3. I authorize my insurance benefits to be paid to NEUROPSYCHOLOGY ASSOCIATES, P.A.
4. If a requested insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept the responsibility for collection of your insurance claim or for negotiating settlement on disputed claims. I understand I am responsible for any charges not paid by my insurance.

Patient's signature (unless minor) _____ Date: _____/_____/_____

Notice of Privacy Practices Acknowledgement

Neuropsychology Associates, P.A.
1220 Main Ave, Suite 100
Fargo, ND 58103

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
Signature: _____
Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below

Date _____ Initials _____ Reason_____

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- ❖ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- ❖ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ❖ The right to inspect and copy your protected health information.
- ❖ The right to amend your protected health information.
- ❖ The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- ❖ The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Mary Jo Olmstead
Neuropsychology Associates, P.A.
1220 Main Ave, Suite 100
Fargo, ND 58103
701-297-7588

For more information about HIPAA
Or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NEUROPSYCHOLOGY ASSOCIATES, PA
COMMUNICATION AUTHORIZATION

May we leave appointment information or return phone call messages with the person who answers the phone? Yes_____ No_____

May we leave appointment information or return phone call messages on your answering machine? Yes_____ No_____ Not applicable _____

CONTACTS:

With whom may we discuss patient's medical information or billing questions?

NOTE:

Please **ONLY** list family members or friends that might call on your behalf.
Example: mom, dad, brother, sister, spouse, significant other, etc

If you choose not to list anyone, please proceed to the bottom to sign and date.

1. _____ Phone_____
2. _____ Phone_____
3. _____ Phone_____
4. _____ Phone_____
5. _____ Phone_____

Print Patient's Name _____

Patient Signature (unless a minor) _____

Date: _____ /_____/_____

Please contact us if you want this information updated.

NEUROPSYCHOLOGY
ASSOCIATES, P.A.

Payment Policy

DEDUCTIBLES/CO-INSURANCE/NON COVERED SERVICES:

-Deductibles/Co-insurances/Non-covered services are to be paid in **FULL** following insurance(s) reimbursement to our clinic. Please contact the clinic should you require other payment options.

If you have any questions, please feel free to contact Mary Jo at 701 297-7588.

Thank You.