NEUROPSYCHOLOGY PARTNERS CHILD PATIENT INFORMATION

Legal First Name: ____________________ M.I. ____ Last Name: ____________________

Preferred Name: ________________ DOB: __________ Sex assigned at birth: M ☐ F ☐

Gender: __________ Pronouns: ______________

Address: ______________________ City, State: ____________________ Zip: __________

Caregiver/Parent 1's Name: ______________________________ DOB: ________________

Email: ______________________________ Phone: ______________________________

Caregiver/Parent 2's Name: ______________________________ DOB: ________________

Email: ______________________________ Phone: ______________________________

Who has physical custody of patient? ________________ Legal custody? ________________

If joint custody, please indicate schedule: ____

Emergency Contact Information (if different from caregivers):

Name: ________________________ Phone: ________________ Relation: _____________

Primary Care Physician (PCP) Information:

Name: ________________________________ Phone: _____________________________

Address: ______________________________ City, State: _______________ Zip: ________

Referral Source (if different from PCP): ___________________________________

Insurance Information:

Type: ____________________ Contract #: ____________________ Group #: ___________

Subscriber Name: ______________________ DOB: ____________ Relation: ____________

Current Medications: ____

Allergies: ____

Reason for Visit: ____

Is Condition Auto Accident Related? __________ If So, Date of Injury: _________________

Auto Insurance Carrier: ____________________ Policy #: ____________________________

CONSENT FOR TREATMENT

I hereby consent for my child to receive and participate in treatment/testing with Neuropsychology Partners.

Parent/Guardian signature: ______________________________ Date: __________________

Neuropsychology Partners Practice Financial Policy

In regards to the fee for the service(s) we will be rendering, we will assist you with a courtesy billing to the primary insurance carrier and any available secondary carrier (s). However, we would like to advise you that **you are responsible for payment for the services rendered.** If we have not secured payment from your insurance company within 90 days, you will be responsible for the bill.

In order to provide the courtesy billing, we need your assistance in providing full and complete information in regards to your health insurance policy and any secondary insurance plan(s) that might be applicable. If we are a non-participating facility with your insurance plan, you may receive all information, such as Explanation of Benefits, and all payments. We need your cooperation in promptly providing our office with originals or copies of any payment, correspondence, rejection notices, etc. that you receive from your insurance carrier(s). We will be happy to provide you with a stamped, addressed envelope for this purpose.

Because insurance plans and benefits vary greatly by individual plan and employer, **we do not quote specific insurance benefits.** As the insured, you are ultimately responsible to know your copay and deductible information. We are more than happy to provide you with the procedure codes we use for billing so that you may contact your insurance company for detailed benefit information.

Additionally, as the insured, you are responsible for knowing if Neuropsychology Partners is in-network with your insurance. We participate with a wide range of insurance plans, however, we do not participate with any Medicaid plans. If you have one of these insurances as primary or secondary, you will be responsible for any copays, deductibles, or balances associated with your visits.

FINANCIAL RESPONSIBILITY STATEMENT:

I understand that the charges for services received may exceed the benefits payable or may not be a covered benefit under my present health insurance plan. I also understand that my cooperation is required in providing Neuropsychology Partners with any and all payments, and copies of the Explanation of Benefits, which accompanies the payment or any notice of rejection of payment. I agree to accept responsibility for providing the necessary paperwork, or copies thereof to secure payment for services rendered.

Additionally, I understand that Neuropsychology Partners has a **48 hour cancellation policy** for all scheduled appointments. We reserve the right to charge a no show/late cancellation fee for appointments that are not cancelled 48 hours prior to the scheduled appointment time. No show/late cancellation fees are as follows:

Psychological or Neuropsychological testing - $150

No appointments will be rescheduled until this fee has been paid or payment arrangements have been made. These late cancellation fees are non-refundable and are not payable by your insurance carrier.

Co-payments are due at the time of the visit, unless other arrangements have been made. There is a $30.00 fee for all returned checks. If your account is 90 days delinquent, services may be discontinued and your account turned over to a collection agency. Additional fees may be assessed for medical records requests and form completion.

I understand and agree to all of the conditions listed above. I agree to accept financial responsibility for payment in full or for any balance remaining after insurance payments has been made to Neuropsychology Partners.

______________________________ ____________

Signature Date

______________________________ ____________

Neuropsychology Partners Employee Date

Neuropsychology Partners
RELEASE OF INFORMATION
TO PRIMARY CARE PHYSICIAN (PCP)

The information released in this authorization is confidential. Further disclosure of this information is prohibited unless otherwise permitted by Federal and State laws.

Patient Name: ______________________________________ **Date of Birth:** ________________

___ I hereby **DECLINE** to allow this facility to release and/or obtain written and verbal information with my Primary Care Physician.

___ I hereby **AUTHORIZE** this facility to release and/or obtain written and verbal information with the Primary Care Physician identified below, and under the conditions specified below:

Primary Care Physician: ____

Phone Number

____

Address

Fax Number

___ Psychological/Neuropsychological Report
___ Psychiatric Records
___ Progress Notes
___ Treatment Plan
___ Verbal Communication
___ School Records
___ Hospital Records
___ Therapy Intake
___ Other: _________________________

The purpose for the disclosure is to assist in the development of a medical treatment plan.
My signature indicates that I know what information is being released, and any consequences that may arise as a result of my signing this authorization, or refusing to sign. I have read this form, or had it read to me and explained in language that I can understand. All the blank spaces have been filled out except for my signature and the dates. This consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on it. Unless this consent has been revoked in writing, it will automatically expire one year from the date signed.

____ ________________________

Patient Signature (Parent/Guardian if Patient is a Minor) Date

____ ________________________

Neuropsychology Partners Employee Date

Authority: from mental health services: Michigan Mental Health Code, PA 258 of 1974 as amended. For substance abuse services: Federal requisitions governing confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR part two and PA 368 of 1978, Michigan Mental Health Code. For HIV, AIDS, and ARC related conditions: PA 271 of 1981, PA 488 of 1989. For communicable and infectious disease records (including venereal disease and TB records) as defined by the Michigan Department of Community Health.

NEUROPSYCHOLOGY PARTNERS
RELEASE OF INFORMATION

The information released in this authorization is confidential. Further disclosure of this information is prohibited unless otherwise permitted by Federal and State laws.

Patient Name: ____ **Date of Birth:**__________________

I hereby authorize this facility to release and/or obtain written and verbal information with the individuals listed, and under the conditions specified below:

Information will be released to / obtained from: **(one individual or office per release, please)**

____

Name Phone Number

____

Address Fax Number

Information to be released and/or obtained:

___ Psychological/Neuropsychological Report
___ Psychiatric Records
___ Progress Notes
___ Treatment Plan
___ Verbal Communication
___ School Records
___ Hospital/Medical records
___ Therapy Intake
___ Other: ______________________

The purpose for the disclosure is to assist in the development of a medical treatment plan.
My signature indicates that I know what information is being released, and any consequences that may arise as a result of my signing this authorization, or refusing to sign. I have read this form, or had it read to me and explained in language that I can understand. All the blank spaces have been filled out except for my signature and the dates. This consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on it. Unless this consent has been revoked in writing, it will automatically expire one year from the date signed.

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Neuropsychology Partners

Notice of Privacy Practices Acknowledgement

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 physician certifications.

I have received, read, and understand 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 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.

Please sign below **acknowledging** that you have received a copy of our notice of privacy practices.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ____________________

Patient Consent

Please sign this form below to consent to our disclosures of your information, to those that you have given us permission to, in order to provide you with proper treatment.

I consent to your disclosures of my information.

______________________________ ______________________________
Patient Signature (Parent/Guardian if patient is a minor) Patient Name (please print)

Date: ____________________

OFFICE USE ONLY

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

Reason: ______________________________

Date: __________ Initials: __________

Notice of Privacy Practices

PATIENT'S RIGHTS, RESPONSIBILITIES, AND CONSENT FOR TREATMENT

MISSION STATEMENT:

Our mission is to provide comprehensive rehabilitation and mental health services to individuals of all ages, with a wide range of disabilities and needs. We provide services for our patients in a mutually respectful and compassionate (supportive) environment. We strive to treat each individual with respect and dignity as we work collaboratively to achieve functional goals and increase independence.

GOALS FOR SERVICE:

The goal of our mental health and substance abuse programs is targeted to help our patients deal with a variety of problems, and to help the patient connect with outside community resources, as needed. The goal for this program too is to help the patient function at his or her maximum potential while supporting the notion of self-determination.

CODE OF ETHICS:

1. Staff shall conduct themselves in a professional manner.
2. Staff shall treat co-workers, professionals in the community, and organizations with respect, and comply with patient confidentiality.
3. Staff shall comply with the ethical codes specific to their disciplines.
4. Staff shall respect the agency property, and comply with all health and safety regulations to assure the protection of staff, patients, and property.
5. Staff shall conduct themselves in a professional and fair manner in their business and marketing manners.
6. Staff shall seek out opportunities for professional growth and attainment for professional knowledge.
7. Staff shall respect all patient rights, treat patients with dignity, and comply with confidentiality guidelines.
8. Staff shall treat all patients as individuals and unique persons, without prejudice regarding their disability, race, creed, color, religion, age, or ethnic background.
9. Staff shall not condone or employ dual or multiple relationships with patients, nor exploit those relationships for personal gain.
10. Staff shall put serving the patient's best interests at their highest priority.

THE THERAPEUTIC RELATIONSHIP:

Neuropsychology Partners' employees and interns shall establish a professional relationship with patients, and therapists shall maintain a professional working relationship based on honesty and trust. Neuropsychology Partners encourages family and friends to support the patient in treatment with the patient's permission. All Neuropsychology Partners' employees and interns must abide by the Neuropsychology Partners code of ethics, and each therapist must also abide by his or her discipline-specific code of ethics. If you feel that an ethical violation has occurred, please contact the Executive Director.

LIMITATIONS OF TREATMENT:

Therapeutic services cannot guarantee complete resolution of problems. However, Neuropsychology Partners' therapeutic staff is committed to providing their best professional efforts to assure patient's goals are met. For treatment to have an optimal impact, patients are encouraged to be committed to the therapeutic process and to follow treatment recommendations.

In some instances, patients may be transferred to other providers or discharged from the practice prior to meeting the goals set out in the patient's treatment plan. Any potential transfers or discharges from service will be discussed with the patient prior to any change taking place. Transfers or discharges can be made at the request of the patient. The provider may also request a transfer or discharge in the event of a conflict of interest or non-compliance on the part of the patient.

AFTER HOURS SERVICE:

If patients require after hours services (weekly after 5:00 p.m. or weekends), they may call Neuropsychology Partners' office at (248)613-9191.

PATIENT RESPONSIBILITIES:

1. Patients have the responsibility to attend at least 90% of treatment sessions.
2. Patients have the responsibility to provide information about themselves as honestly as possible to assure the most appropriate service delivery.
3. Patients have the responsibility to participate in their own treatment planning process.
4. Patients have the responsibility to keep information about other patients confidential (i.e., information shared in group therapy sessions).
5. Patients at Neuropsychology Partners are expected to adhere to a code of conduct whereby they show respect for themselves, respect for others, and a respect for Neuropsychology Partners property. Any individuals displaying disrespectful behavior may be asked to leave the premises and may be discharged.
6. In keeping with Neuropsychology Partners' intent to provide a safe and healthful work environment, smoking is prohibited throughout the premises. This includes all forms of tobacco products, including but not limited to: cigarettes, cigars, chewing tobacco, electronic cigarettes, snuff, etc. In accordance with state laws, smoking is permitted outside the building. Legal and prescription drugs may be brought on site in a secured manner. They must be kept in their original containers and kept out of public view. This can include a purse, briefcase, etc. Neuropsychology Partners prohibits the use and/or distribution of illegal substances throughout the premises.
7. Neuropsychology Partners maintains a weapons free policy throughout the entire campus. This policy applies equally to all employees, patients, and visitors.

PATIENT RIGHTS:

1. Patients have the right to be treated with dignity and respect.
2. Patients have the right to be treated in a safe environment.
3. Patients have the right to be free from abuse, whether be emotional, physical, or sexual. Patients shall not be psychologically abused, including humiliating, threatening, or exploitative actions.
4. Patients have the right to confidentiality. All patient records are kept confidential. Neuropsychology Partners complies with all federal and state confidentiality regulations.
5. Patients have the right to be informed of their treatment status and progress. Patients may request status reports of their treatment progress at any time, from any of their therapists.
6. Patients have the right to have access to their records via an approved procedure.
7. Patients have the right to information about their billing and account balances.
8. Patients have the right to receive treatment at Neuropsychology Partners that is appropriate to their needs.
9. Patients have the right to file any complaints about their rights with the Neuropsychology Partners Patient Rights Advocate.
10. Patients have the right to utilize staff advocates to assist with referrals for appropriate services (i.e., self-help groups, guardians, or conservators).

CONFIDENTIALITY:

Neuropsychology Partners holds all information given by patients as confidential except in the following instances:

1. Information regarding the threat of harm to self or to others. Neuropsychology Partners has the legal and ethical duty to report such information to the proper authorities.
2. Cases of suspected child abuse or adult abuse must be reported by law.
3. When necessary to comply with provisions of the law.
4. If the patient has been adjudicated as not being competent, and has a legal guardian. If the patient has not been adjudicated, however, Neuropsychology Partners assumes the patient is competent to give an informed consent.
5. All clinical personnel are designated as "Mandated Reporters" and have a duty to warn in the event of a critical incident. A "critical incident" is any actual or alleged event or situation that creates a

significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant. Any person who becomes aware of a critical incident is required to report the incident.

Formal Complaints:

While all formal complaints are routed through the Patient Right's Advocate, any staff member at Neuropsychology Partners can assist you in filing a complaint. Patients will not be criticized, humiliated, degraded, threatened, or discharged from services for filing a Patient Right's Complaint. Neuropsychology Partners staff members may file a Patient's Right Complaint on your behalf at any time as well. If you choose to terminate services from Neuropsychology Partners as a result of a right's issue, the Patient Rights Advocate will assist you in finding additional suitable services elsewhere without threat or reprisal.

Complaints can be filed:

- Anonymously: A patient who files a complaint would not indicate their name on the form. (However, this patient may not be entitled to knowledge of the resolution or remedial action).
- Confidentiality: The patient name is kept private and only given to the Executive Director.

All formal complaints are documented. Written analyses of all formal complaints are prepared annually. Analyzing the formal complaints that Neuropsychology Partners received in the course of the year allows us to understand areas for improvements. Neuropsychology Partners takes formal complaints seriously and makes sure that any mistakes made are corrected and not made again. If changes need to be made to the policies and procedures at Neuropsychology Partners to correct complains, the appropriate actions are taken and implemented.

Verbal Complaint

All patients may discuss a Rights Complaint with any staff at any time. A verbal complaint will be documented, reviewed, and the patient will be contacted about the results if requested. The Patient Rights Advocate can also be contacted via telephone at (248) 613-9191 to take your verbal complaint over the phone.

Written Complaint

A patient may wish to file a complaint in writing. Neuropsychology Partners has an established Patient Complaint Form that can be made available to anyone wishing to file a written complaint. This form can be obtained from any staff member or at the front office. Patients may also wish to fill out their own complaint form or draft a letter of complaint. All written complaints can be dropped off in the office or mailed to Neuropsychology Partners. They should be directed to the attention of the Patient Rights Advocate or the Executive Director.

CONFIDENTIALITY OF RECORDS RELATED TO ALCOHOL AND DRUG ABUSE:

Confidentiality of patient records related to alcohol and drug abuse is protected by federal law and regulations. Generally, Neuropsychology Partners may not disclose information identifying a patient as an alcohol or drug abuser unless:

(1) the patient consents in writing;
(2) the disclosure is allowed by a court order;
(3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
(4) the patient commits to threatens to commit a crime either at the program or against any person who works for the program.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurred.