# GEORGIA NEUROPSYCHOLOGY PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient's Name (Last, First, M.I.) | | Social Security # | | Marital Status<br>S M W D Sep |
| Birth Date (Month / Day / Year) | | Age | | Sex<br>M F |
| Street Address | | City | St | Zip Code |
| Home Phone # | Work Phone # / Ext. | E-mail | | |
| Patient's Employer | | Occupation | | How Long Employed |
| Employer's Street Address | | City | St | Zip Code |
| Person to Contact in case of Emergency | | Relationship | | Phone Number |
| Street Address | | City | St | Zip Code |
| Guarantor | | Referred by | | |
| Level of Education Completed? | | Date of Injury<br>Injured on the job? Yes No | | |

I request that payment of authorized insurance company benefits be made either to me or on my behalf to Georgia Neuropsychology or Steve Shindell, PhD for all services furnished to me by the physician/supplier. I authorize Georgia Neuropsychology and/or Steve Shindell, PhD or its authorized agent to release services and medical information to Medicare, insurance company and/or its agents needed to determine these benefits or the benefits to related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form is completed, (secondary insurance box), my signature authorizes releasing of the information to the agency shown.

Payment is expected at the time of service unless other arrangements are made prior to the appointment.

I am aware and understand that my credit card will be charged for the allocated time reserved for my appointment unless 24 hour (ONE BUSINESS DAY) advance notice is given, and that I am responsible for these charges.

I hereby authorize the release of information acquired during the course of my examination and treatment to the Health Care Financing Administration and its party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of said benefits to include Medicare benefits directly to the provider and I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. Authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original and fully understand the terms thereof.

I understand that regardless of any insurance coverage, I am financially responsible for all charges generated. Office policy requires payment at the time of service. Should insurance benefit assignment be accepted, any non-paid services will be paid by me within 30 days of notification. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% of that outstanding balance. I waive confidentiality to Attorneys, Collection Agencies, and/or Credit Bureau if I do not pay my bill. I understand that I will be responsible for any and all fees that are incurred during the collection process. I also understand that my Credit Card will be billed for any and all unkept appointments and late cancellations, unless special circumstances apply and arrangements have been made in advance with management.

I have read the HIPAA PSYCHOLOGIST-PATIENT SERVICES AGREEMENT and agree to its terms.

- o Please check here if you wish to have a copy of the HIPAA notice form to keep for your records.

| | | | |
|---|---|---|---|
| Type Credit Card<br>VISA Mastercard | Credit Card Number | | |
| Name on Credit Card | | Expiration Date | |
| Credit Card Billing Street Address | City | St | Zip Code |

The following signature serves as acknowledgment of and agreement to all information contained on this form, including credit card authorization for applicable charges.

| | | |
|---|---|---|
| Signature | Print Name | Date |

# GEORGIA NEUROPSYCHOLOGY PATIENT INFORMATION

**Insurance Information – PRIMARY INSURANCE:**

| **Following Information is related to the Primary Person on the insurance plan –** | | | | **Is the patient the primary insured? Y / N** |
|---|---|---|---|---|
| Patient Relationship to Insured | | Insured's SSN | | Insured's DOB |
| Insured's Name (Last, First, Middle) | | | | Insured's Sex M / F |
| Street Address | | City | St | Zip Code |
| Home Phone # | Work Phone # / Ext. | E-mail | | |
| Insured's Employer | | Occupation | | How Long Employed |
| Employer's Street Address | | City | St | Zip Code |
| Insurance Carrier | | | | |
| Street Address | | City | St | Zip Code |
| Contact | | Phone | | Fax |
| Account # | | Group or FECA # | | PIN # |
| Insurance Plan / Program | | Source | | Type |
| Authorization Number: | | Notes: | | |

**Insurance Information – SECONDARY INSURANCE:**

| **Following Information is related to the Primary Person on the insurance plan –** | | | | **Is the patient the primary insured? Y / N** |
|---|---|---|---|---|
| Patient Relationship to Insured | | Insured's SSN | | Insured's DOB |
| Insured's Name (Last, First, Middle) | | | | Insured's Sex M / F |
| Street Address | | City | St | Zip Code |
| Home Phone # | Work Phone # / Ext. | E-mail | | |
| Insured's Employer | | Occupation | | How Long Employed |
| Employer's Street Address | | City | St | Zip Code |
| Insurance Carrier | | | | |
| Street Address | | City | St | Zip Code |
| Contact | | Phone | | Fax |
| Account # | | Group or FECA # | | PIN # |
| Insurance Plan / Program | | Source | | Type |
| Authorization Number: | | Notes: | | |

# GEORGIA NEUROPSYCHOLOGY PATIENT INFORMATION

**Patient Record of Disclosures**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The referring physician or referral source will be sent a copy of records to ensure continuity of care.

**I wish to be contacted in the following manner (check all that apply):**

**Home Telephone**
- o O.K. to leave message with detailed information
- o Leave message with call-back number only
- o Do not leave message

**Work Telephone**
- o O.K. to leave message with detailed information
- o Leave message with call-back number only
- o Do not leave message

**Written Communication**
- o O.K. mail to my home address
- o O.K. to mail to my work/office address
- o O.K. to fax to this number _____

**E-mail**
- o O.K. to leave message with detailed information
- o Leave message with call-back number only
- o Do not leave message

| Patient Signature | | Date |
|---|---|---|
| Print Name | Social Security # | Birth date |

**OFFICE USE ONLY BELOW**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

*Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

**Record of Disclosures of Protected Health Information**

| Date | Disclosed to Whom (Name) | Address or Fax Number | 1 | Description of Disclosure | Purpose of Disclosure | Disclosed by Whom (Name) | 2 | 3 |
|---|---|---|---|---|---|---|---|---|
| | Referral Source | | ✓ | Clinical Report | Continuity of care | Dr. Shindell | T | FPM |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Key Code
1. Check this box if the disclosure is authorized
2. Type key: T = Treatment Record; P = Payment Information; O = Healthcare Operations
3. Enter how disclosure was made: F = Fax; P = Phone; M = Mail; E = Email; O = Other