

The NeuroDevelopment Center
260 West Exchange Street, Suite 302
Providence, RI. 02903
(401) 351-7779

Date: _____

Patient name: _____	Neurologist/Mental Health Provider (i.e. counselors, psychologists, etc.)
Sex: _____	1) Name: _____
Date Of Birth: _____	Address: _____
Address: _____	_____
Email: _____	Phone: _____
Home Phone: _____	2) Name: _____
Work Phone: _____	Address: _____
Occupation: _____	_____
Employer/School: _____	Phone: _____
Patient's Primary Care Physician:	3) Name: _____
Name: _____	Address: _____
Address: _____	_____
Phone: _____	Phone: _____

Please complete if patient is a child:

Mother's name: _____	Father's name: _____
Address: _____	Address: _____
_____	_____
Home phone: _____	Home phone: _____
Work phone: _____	Work phone: _____

Insurance Co. #1: _____	Insurance Co. #2: _____
Plan type: _____	Plan Type: _____
Group #: _____	Group #: _____
Subscriber's ID#: _____	Subscriber's ID#: _____
Subscriber's name: _____	Subscriber's name: _____

Party Responsible for Payment:	Reason for Referral:
Name: _____	_____

How did you hear about The Neurodevelopment Center?	_____
_____	_____
_____	_____
_____	_____

Please read pages two and three and sign to indicate your understanding of and agreement to the terms for provision of psychological services as described there.

For office use only: Dx:

TERMS OF PROVISION OF PSYCHOLOGICAL SERVICES

Please read carefully the information that follows, so that you may provide your informed consent to a number of necessary conditions for provision of services from The NeuroDevelopment Center. Should you have any questions about any of them, please discuss them with The NeuroDevelopment Center professional you are seeing.

Release of information

Results of diagnostic evaluations and reports regarding treatment goals and progress are sometimes required by insurance companies and their designated utilization review companies for purposes of authorizing payment. You understand that this information may be provided by The NeuroDevelopment Center for such purposes and indicate your agreement and consent to release this information by signing below.

Telephone procedures

Should you have an emergency, you may call The NeuroDevelopment Center and leave a message at any time. In the event of an emergency after business hours, if you are unable to reach The NeuroDevelopment Center professional, you are advised to contact the emergency department at Rhode Island Hospital, 444-5411. During The NeuroDevelopment Center professional's absences, arrangements will be made for coverage. Please indicate your understanding of and consent to these telephone procedures as described in this paragraph, by signing below.

Limits to Confidentiality

Personal information that you communicate in the course of treatment is confidential and may not be disclosed to any other person without your written consent. However, there are limits or exceptions to the confidentiality of your records. No consent for the release or transfer of confidential information is required in the following situations: to legal authorities or to any individual at risk of harm in order to protect you or anyone else from physical harm, if The NeuroDevelopment Center professional believes that you might hurt yourself or someone else or be hurt; to parents or legal guardians, if The NeuroDevelopment Center believes that that information is necessary in order to help a parent or legal guardian care for the child; to the courts or child welfare authorities or the court, if a child welfare matter is being considered in court; to a court or legal authority if so ordered by the court; to a malpractice insurance carrier or lawyer if The NeuroDevelopment Center professional has reason to expect a medical liability action or if medical liability action is brought; to third party health care insurers or their utilization review companies for the purpose of adjudicating insurance claims; to other parties for other purposes as specified in the Confidentiality of Health Care Information Act, Chapter 37.3. You may request a copy of this act from The NeuroDevelopment Center should you have any questions about the limits of confidentiality of health care information as described above. Please indicate your understanding of these limitations and your consent to these conditions by signing below.

Ongoing communication

The NeuroDevelopment Center may send out periodic announcements of new services or of new research or techniques that may be of interest to our clients. Please indicate your consent to our sending you this information by signing below.

Signature
Date

Client Financial Agreement

Our primary goal is to provide you with quality mental health services. In order to allow our staff to focus on this care, we have developed the following policies regarding payment for services.

Responsibility for fees

- The NeuroDevelopment Center does not accept assignment from most insurance companies. Each client is responsible for payment of all fees at the time that the service is delivered. We will provide you with a statement after each session which will contain all the information needed by your carrier to determine reimbursement.
- We cannot and do not guarantee that an insurance company will reimburse you for any of our services. Although we will provide you with information about what has been reimbursed for others, do not take this as a guarantee that they will do so for you.
- Do not assume that any insurance reimbursement made to you by your insurer for one of our services will be made for a different type of service. **Be sure to check with your insurer regarding coverage for each type of service you obtain from our Center.**
- If a service is to be paid by a school system, we will need to have written acceptance of responsibility to pay for the service by a school official prior to service.
- If your check is returned, a \$35 returned check fee will be assessed.
- The NeuroDevelopment Center utilizes a collections agency. If your account is still unpaid after four statements, your account will automatically be sent to collections. It is the policy of our collections agency to report delinquent accounts to credit bureaus. If your account is sent to collections, you will be responsible for the collections fees and attorney fees, in addition to the original charges.
- Should there be any change in your financial circumstances, making for financial hardship, please discuss this with our office manger as soon as possible so that we may make arrangements for payment.

Time of Payment

- Payment is due at the time of your visit. You may pay with cash, check, credit card, or money order. If you plan to pay by check, please have a check ready to give to the receptionist when you check in.
- We will keep a signature and credit card information on file for every client. In the event that you cannot or do not pay the fee for your visit, we will submit a charge to your credit card. We ask you to sign below indicating your agreement and consent to this procedure. Your card will be charged only if you do not pay at the time of your visit, or if you prefer that means of payment. **No services can be provided without this agreement.**

Billing information

- Please notify us immediately if there is any change in your billing information.
- Please address questions about billing to our office manager, 401 351-7779, extension 100.

Cancellations/missed visits

- Should it be necessary to cancel an appointment, please contact The NeuroDevelopment Center at least 24 hours in advance. Without this notice, the standard fee will be charged.
- You will be charged unless the appointment can be rescheduled in the same calendar week.
- Even if we do accept your insurance, you will be responsible for the full fee for the session, which will not be paid by insurance. It will be billed as an administrative charge.

I have read and understand the policies described above and agree to these terms regarding fees and payment. My credit card information is:

Card type	Name on card	Card number	Exp date
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Print name	Signature	Date
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The NeuroDevelopment Center
260 West Exchange Street, Suite 302 Providence, RI 02903

Authorization Form

This form when completed and signed by you, authorizes The NeuroDevelopment Center to release protected information from your clinical record to the person you designate.

I authorize The NeuroDevelopment Center to release the following information: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to (name and address of person to whom the information is to be released)

I am requesting that The NeuroDevelopment Center release this information for the following reasons: (“at the request of the individual” is all that is required if you do not desire to state a specific purpose.)

This authorization shall remain in effect until (fill in expiration date) _____
or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that The NeuroDevelopment Center generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

The NeuroDevelopment Center
260 West Exchange Street, Suite 302 Providence, RI 00903

RHODE ISLAND 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

We 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 we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose 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 our practice. 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 our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We 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 we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have 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) we have 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

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

- **Child Abuse:** If we have reasonable cause to know or suspect that any child has been abused or neglected, as defined below, or is a victim of sexual abuse by another child, we must, within 24 hours, transfer that information to the Rhode Island Department of Child, Youth and Families, or its agent.

Child abuse and/or neglect is defined as a child whose physical or mental health or welfare is harmed, or threatened with harm when his or her parent or other person responsible for his or her welfare:

- 1) Inflicts, or allows to be inflicted physical or mental injury;
 - 2) Creates or allows to be created a substantial risk of physical or mental injury;
 - 3) Commits or allows to be committed an act of sexual abuse, sexual assault against, or exploitation of the child;
 - 4) Fails to supply the child with adequate food, clothing, shelter or medical care;
 - 5) Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his or her unwillingness or inability to do so; and abandons or deserts the child.
- **Health Oversight:** If a complaint is filed against us with the Rhode Island Board of Psychology, the Administrator of Professional Regulation (of the Division of Health) has the authority to subpoena confidential mental health information from us relevant to that complaint.
 - **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we provided to you and the records thereof, such information is privileged under state law, and we will not release this information without: 1) written authorization by you or your legal representative; or 2) a subpoena of which you have received official notification and you have failed to inform us that you are opposing the subpoena; or 3) a court order. The 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.
 - **Serious Threat to Health or Safety:** We may release your confidential health care information to appropriate law enforcement personnel, or to a person if we believe that person or their family to be in danger from you.
 - **Workers' Compensation:** If you file a worker's compensation claim, we must release your relevant mental health care information for the proceedings.

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, we are 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 seeing us. Upon your request, we 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 our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we 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 regarding you. On your request, we 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 us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are 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.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a revised notice in person at the time of your visit.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Anita Heal, Office Manager of The NeuroDevelopment Center at (401) 351-7779 for further information. 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.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in person at the time of your visit.



ONLY FOR NEUROPSYCHOLOGICAL ASSESSMENTS REQUESTED BY SCHOOL DEPARTMENTS

Dear Parent,

Your school department has requested that we submit the bill for today’s neuropsychological assessment to your health insurance company for reimbursement. They will cover any balances unpaid by your carrier.

Please sign on line 1 below to indicate your agreement with this procedure.

If you do not agree to this procedure, please sign on line 2 below.

Child’s name: _____

Parent’s name: _____

Date: _____

1. I agree to have my insurance billed: _____
Parent’s signature

2. I do not agree to have my insurance billed: _____
Parent’s signature