Carmel Neuropsychology Services, P.C.
755 West Carmel Drive, Suite 205
Carmel, IN 46032
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NEW PATIENT INTAKE AND AGREEMENT

PLEASE CAREFULLY READ AND COMPLETE. SIGNATURES AND INITIALS MUST BE DIGITALLY SIGNED IN A PDF READER OR IN WRITING. TYPED SIGNATURES OR INITIALS WILL NOT BE ACCEPTED. To complete this fillable form, you will need to download the document and open in a free PDF reader (not website browser).

Today's Date: _____ Patient Name: _____

Age: _____ Birthdate: _____ SS#: _____

Street Address: _____ City: _____ Zip: _____

(If Applicable. **IF GUARDIAN OR POA CHECKED PLEASE INCLUDE RELEVANT DOCUMENTATION**)
Parent ☐ Guardian ☐ Power of Attorney ☐ Name: _____

Guardian's Birthdate: _____ Guardian's SS#: _____ (N/A if not applicable)

Guardian's Address: _____ City: _____ Zip:_____

Email that <u>will be checked regularly</u> for all communications from the office: _____

Cell Phone for receiving all text messages from the office: _____

Consent for Treatment

I hereby consent and agree to specialized neuropsychological services provided with (a) the scope of the provider's license, certification and training; or (b) the scope of the license, certification, and training of the provider directly supervising services rendered by other members of the CNS, P.C. staff.

I understand all information regarding diagnosis and/or treatment is confidential and **will <u>not</u> be released to any other agency/individual without my knowledge and consent**. A separate release of information for each request will need to be accompanied by appropriate written and signed documents. (See the release of information request form found on the website). You will be responsible for your records. Records will be kept for 7 years per practice standards. Additional requests for records will be charged.

By signing and dating this document, I authorize a **<u>one-time release and only one record – (not including my complimentary mailed paper copy)</u>** of my results or report (depending on which evaluation is chosen below) to my referring provider or other designee at the completion of the evaluation process:

Provider/Designee to receive records: _____

Relationship of Designee to Patient: _____

Fax Number: _____ Email: _____

_____ _____
Patient/Guardian/POA Signature Date

Limits to Confidentiality

I understand that there are some exceptions for breaking confidentiality when required by law which can include danger to others (such as elder/child abuse or neglect) or danger to self (if there is serious intent to harm myself or another person).

Please be aware that you will waive your right to confidentiality if you post anything to social media or request a third party investigating your care become involved. In those instances, I understand and agree that **I have by my own accord chosen to waive my confidentiality, and I authorize CNS, P.C. to share all of my protected information, when necessary, in order to appropriately respond to any social media or third-party entities investigating my care**.

I AGREE AND CONSENT TO THE CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY AS NOTED ABOVE (INITIALS) _____

Insurance Claims

CNS, P.C. believes that patients should have the freedom and right to choose their medical care based on medical need rather than dictated by cost containment Insurance standards. As a result, CNS, P.C. offers flat rate services to avoid the delays and obstacles of insurance. Research shows that this gold standard of care results in an **average of 3 to 9 month quicker completions rate, better evaluations not limited by insurance, and ultimately results in more effective and efficient treatment, better access to care, and better patient well-being and satisfaction**.

CNS, P.C. maintains credentialing through most insurance companies, but **effective 4/1/2022 CNS, P.C. will not submit claims to insurance companies or be involved in any insurance pre-certification, authorization, submission, claims rejections, or appeals**. Not only does this cut costs to our patients, but it allows for us to focus on patient care and provide appropriate and medically necessary care not limited by insurance company policies.

Upon completion of your services (and if requested), you can be provided – (along with your **mailed paper report or results** if you have completed an evaluation) a receipt so that you can file with your insurance company for reimbursement. **It will be the patient/guardian's responsibility to file their own claims and receive any refund as dictated by your insurance company and plan options you have selected with them**. Medicaid/Medicare plans are not eligible for claims reimbursement and prohibited from use in this way. If necessary for your claim submission, any insurance forms should be completely filled out so that only the doctor's signature is required.

I AGREE AND CONSENT TO THE INSURANCE CLAIMS AND UNDERSTAND THAT I WILL INDEPENDENTLY SUBMIT MY CLAIMS TO MY INSURANCE COMPANY SHOULD I DESIRE TO DO SO (INITIALS) _____

No Show/Late Arrival Policy

I acknowledge that if I am late to an appointment that CNS, P.C. will need to modify my evaluation process for the remaining time which may result in less or incomplete results. I agree that I will make contact **before the start of my scheduled appointment** with CNS, P.C. at the email or phone listed on the website if I am expecting to be late. **I understand and agree that if I fail to make contact before the start of my scheduled appointment that this will be considered a no show, and understand providers will not wait for the duration of the scheduled appointment time if I do not make contact prior to the appointment start time.** I hereby consent and agree that if I do not show or are a no show for an appointment that has been scheduled and confirmed by CNS, P.C. that I waive the payment made to CNS, P.C. for their time set aside for that appointment.

Note: Cancellations must be made at least 2 business days (48 hours or more if during the weekend or holiday) before your scheduled and confirmed appointment or the patient will be charged the full appointment price.

I AGREE AND CONSENT TO THE NO SHOW/LATE ARRIVAL POLICIES (INITIALS) _____

Payment, Fee Processing, and Claims Policy

To accommodate you, we accept check, cash (in the exact amount due), or money order. We also offer payment options for credit cards; however, **a credit card processing fee of 4% will be added to your principal due to cover the transaction fee.** If you wish to avoid this fee, we recommend paying instead by check, cash, or money order; **however, you must still provide a credit card on file in the event your case becomes forensic in nature.** Please allow 3 days for credit card processing fees to clear and 8 days for checks to clear.

Once your payment has cleared, scheduling will reach out to you by the email selected above to offer an appointment.

IF I CHOOSE TO FILE MY OWN CLAIMS WITH MY INSURANCE COMPANY, I agree to be responsible for all services and fees rendered to me and my family regardless of insurance benefits. I understand that if I choose to file my own claims through my insurance carrier, that they (the insurance company) will determine a refund to me – if any – based on the plan and coverage I have selected with them. I understand that CNS, P.C. will **NOT** seek prior authorization for services nor be involved in filing any claims with insurance, communication with insurance, or appeals processes.

I understand that it is my responsibility to research my coverage and benefits with my insurance company prior to agreeing and participating in services. The following are the Service and CPT codes used by CNS, P.C. but may change with updates to CPT codes.

Service	CPT code
Initial Interview	90791, 99243
Neurobehavioral	96116
Neuropsychological Testing	96132, 96133, 96136, 96137
Psychotherapy/Behavioral Training	90837
Cognitive Remediation (per 15 minutes)	97532
Biofeedback/EMDR	90901, 96152
Psychological Intervention for Medical Disorder	96152

I understand that **my insurance company's authorization of services or any communication I have with them is not a guarantee of payment or refund to me. This communication and file processing will be kept exclusively between me and my insurance company.**

I UNDERSTAND AND AGREE TO THE PAYMENT, FEE PROCESSING, AND CLAIMS POLICIES.
(INITIALS) _____

Forensic Fees

I understand and agree that establishment of forensic categorization to my services at CNS, P.C. is **not time specific or time limited**.

Forensic cases include but are not limited to: (1) **any** establishment of functioning to be utilized in a legal setting (including establishment of disability), (2) determination of capacity ("competency"), (3) **any** involvement with attorneys or court system, or (4) **any** involvement with probation or parole system.

I agree to inform CNS, PC **in advance of any scheduled appointments** of any current or pending legal proceedings, involvement in court or probation/parole system, or involvement in disability proceedings or capacity determination.

As a result, I understand and agree that if my case is determined **at any time** to be forensic in nature (including receiving legal documents, court orders, disability determination, social security requests, and similar documents on your behalf by a third-party entity), then **forensic rates will be applied and based on time spent on the case**.

By signing and pursuing services with Carmel Neuropsychology Services, P.C., I will be fully responsible for payment for any **additional expenses for services** rendered for **any time spent on the case** that I may have not already paid consistent with the providers billed hourly FORENSIC rate and **I hereby authorize immediate payment of the difference to my card on file**.

Current and/or pending legal proceedings/court involvement/parole or probation system/disability or capacity determination (If applicable). PLEASE ATTACH A SEPARATE RELEASE OF INFORMATION FOR EACH PARTY:

Court/Entity/Third Party Involved: _____

Attorney Name: _____

Contact Information: _____

I UNDERSTAND THE FORENSIC DEFINITION AND AGREE TO BE FULLY RESPONSIBLE FOR ANY ADDITIONAL FEES FOR TIME SPENT ON MY CASE AND AUTHORIZE PAYMENT TO MY CREDIT CARD ON FILE. (INITIALS) _____

Evaluation Service Plans

CNS, P.C. offers **3 flat rate Evaluation service plans**. Please carefully review and **select which option you would like**:

A: Brief Evaluation

Pros:	Cons:
Fastest to complete	Limited evaluation
Cheapest service	Only receive test scores
	Provisional, not definitive diagnosis
	No records or history review

A: What You Receive

Brief testing
Test scores
Provisional diagnosis

B: Comprehensive Evaluation

Pros:	Cons:
Personalized full report	More expensive
Functional brain mapping	Slower to complete
Functional application	
Incorporated history	
Incorporated records review	
Clear differential diagnosis	
Optimal for treatment outcome	

B: What You Receive Initial

Interview and Neurobehavioral (max 1 hr)
Records review
Two 3-hour testing sessions
Results analyzed and interpreted
Comprehensive report and impressions
Functional brain mapping
Functional application
Personalized treatment recommendations
Feedback session (max 1hr) to discuss results

C: Forensic Neuropsychological Evaluation

These will be billed at a flat rate for any time spent on the case whether face to face or not.
Each forensic evaluation is unique and requires a different amount of time and services.
Please contact billing@carmelneuro.com to discuss options and how to set up a retainer for services.

By signing below, I authorize payment for the option selected below.

I choose to pursue option [please check box(es) below as applicable]:

Evaluation Services

☐ A: Brief Evaluation ($900) Reason for Referral:
Instructions - Return this completed form (and POA/GUARDIAN FORMS IF APPLICABLE) **with your payment.** After your payment has cleared, scheduling will reach out to you.

☐ B: Comprehensive Evaluation ($4200)
Instructions - Return this completed form **AND** the completed **Developmental History (age specific)** (and POA/GUARDIAN FORMS IF APPLICABLE) **with your payment**. After your payment has cleared, scheduling will reach out to you.

☐ C: Forensic Evaluation (Contact for pricing)
Instructions – Due to the unique nature of each Forensic Case, please submit this completed form (and POA/GUARDIAN FORMS IF APPLICABLE) to billing@carmelneuro.com for your individualized proposal.

Treatment Services

CNS, P.C. also offers the following other services (check as appropriate):

Instructions – For any of the treatment services below return this completed form (and POA/GUARDIAN FORMS IF APPLICABLE) with your payment. **You may pay for multiple sessions if desired.**

☐ D: Consultation ($300 for 50 minute session)

☐ E: Sport Performance Coaching ($1000 per month)

☐ F: Biofeedback ($300 per session)

☐ G: Cognitive Remediation ($300 per session)

☐ H: Cognitive Training/Enhancement ($300 per session)

☐ I: Psychotherapy/Behavioral Training ($300 per session)

☐ J: Psychological Interventions for Medical Disorders ($300 per session)

Payment Method **(If paying by cash, check, or money order, please mail the payment to our office address)**

☐ Cash	☐ Money order/Check	☐ Credit Card (note processing fee you agreed to above) Name on Card: _____ Card Number: _____ Expiration MM/YY: _____ CVV: _____ Zip associated to the card: _____

I hereby authorize payment for the services I have checked above for the amount specified. A credit card must be on file in the event your case becomes forensic as noted above. (Payment clear before an appointment is scheduled).

_____ _____
Patient/Guardian/POA Signature Date

Conduct

I hereby agree to be responsible for me and my family member's conduct while in the waiting room, and I agree that I will leave the office out of respect for quiet needed for other patients if necessary. Additionally, I agree to silence cell phones or electronic devices and step outside for phone conversations.

If I make a mess or my family members makes a mess in the office, I will clean it up.

No food or drink will be allowed in the office. Any snacks or drinks safely stored (unopened) and must be consumed outside of the office.

I agree to keep my shoes and feet off of the furniture in the office.

I hereby agree that if there is damage to CNS, PC property or evaluation materials as a result of my or my family member's actions that I will be fully responsible for the complete replacement costs and **I authorize payment immediately with the credit card on file**.

I understand that CNS, PC has a **zero-tolerance** policy for profanity, verbal threats, harassment, or acts of violence of any kind.

> This includes: (1) Actions taken or words conveyed with the purpose to intimidate, threaten, or harass; (2) Using profanities or obscenities; (3) Raising one's voice above an appropriate level; (4) Personal attacks; (5) Gesturing in a manner that causes one to fear for their safety; (6) Invading, or remaining in one's personal space after being asked to move away; (7) Physically blocking others from moving about freely; or (8) Using physical force, or threat of physical force.

This behavior **will not be tolerated**, and this will result in **immediate** termination of services with CNS, PC regardless of the stage of completion or progress in the evaluation or treatment **without refund of any previously processed payments for services**. Staff and patients have the right to a safe, serene, and respectful environment at all times.

I AGREE TO ABIDE BY THE POLICIES OF CONDUCT TO ENSURE SAFETY TO MYSELF AND OTHERS.
(INITIALS) _____

Preparation for Your Appointment

I understand and agree that all required forms (including POA/GUARDIAN FORMS IF APPLICABLE) and payments must be completed and returned **before** an appointment will be provided.

I will read the what to expect and FAQ pages of the website and agree to follow up to date postings as noted.

I understand that in an effort to sanitize the office space and in order to ensure optimal safety for patients and staff, the office door will **remain locked** at all times. You will be admitted to your appointment when your appointment begins.

You will be required to wear an N95 mask or better at all times while in the office regardless of vaccination status. This is to protect and respect others (including those immunocompromised).

I understand that all communication will be done in a written format and email is the preferred method of communication. I agree to regularly check and respond timely to all emails sent to the designated email I have provided above. The purpose of this method of communication is for multiple reasons including to fully document everything being communicated, so patients have a record and access to all information at all times, and to accommodate all cognitive abilities. At times, I may receive text message reminders to the cell phone listed above in regards to these important written communications to my email listed on this form above.

I agree to have picture identification for each session.

I understand and agree that in order to protect others only one patient will be present at all times.

- Adults are allowed only themselves. If the adult patient has a legally appointed guardian or power of attorney, they will need to attend as well and are allowed to accompany the patient.
- Minors can be accompanied by only one parent or guardian.
- Please note that others can be accommodated by telephone to participate as needed if desired or appropriate for the appointment.

I have located the office location and I am aware that the office is located **inside the building on the second floor**.

To be fully prepared for my evaluation session(s), I agree to ensure that:

- I will have adequate rest the night before the evaluation.
- If I am on medication that may compromise the testing results and if possible, I will work with my prescriber to temporarily discontinue the medication during certain evaluation appointments in order to ensure the most accurate baseline of functioning.
- I understand and agree that significant delays in completing the comprehensive evaluation process – whatever the cause – may result in confounded results.
- I understand that the **results** will be disseminated at the feedback session for a **comprehensive evaluation** or mailed to me (without consultation) for a **basic evaluation**. If I choose not to complete the evaluation process, there will be no results to share to myself or ROI designees.

I understand that the brain changes over time. As a result, I understand that the results are time limited and applicable for no more than 3 to 6 months post evaluation. As such, the results should not be used for treatment planning past this time. A follow up evaluation would be most appropriate past 6 months.

I HAVE REVIEWED THIS INFORMATION AND I AM FULLY PREPARED FOR MY APPOINTMENT.
(INITIALS) _____

I HAVE CAREFULLY READ ALL OF THE INFORMATION IN THIS AGREEMENT **AND ON THE WEBSITE**, AND I UNDERSTAND AND AGREE TO BE LEGALLY BOUND TO THE FOREGOING.

_____
Patient Name

_____ _____
Patient, Guardian, or Power of Attorney Signature (as applicable) Date

PLEASE RETURN THIS COMPLETED PDF FORM (AND ALL OTHER FORMS PER YOUR INSTRUCTIONS PROVIDED IN THIS DOCUMENT) BY EMAIL, FAX, OR BY MAIL. IF PAYING BY CASH, CHECK, OR MONEY ORDER, YOU MUST RETURN THIS DOCUMENT BY MAIL WITH YOUR PAYMENT.

PLEASE NOTE THAT **PDF FORMAT** IS THE ONLY FILE FORMAT WE CAN ACCEPT DIGITALLY.

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