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

PLEASE CAREFULLY READ AND COMPLETE ALL SECTIONS MAKING SURE TO INITIAL AND SIGN. GUARDIANS (IF ASSIGNED) MUST COMPLETE THIS FORM FOR PATIENTS. THANK YOU.

(SKIP THIS SECTION **ONLY IF YOU ARE PRIVATE PAY OR FORENSIC)**

Full Name of Primary Insured _____
Full Name of the Patient (If Different than Primary Insured) _____
Date of Birth of the Patient and Primary Insured _____
Email Address _____
Phone Number _____
Home Address _____
Insurance Company Name _____
Insurance Company Entity (if applicable) _____
Member ID Number _____
Insurance Phone Number for Eligibility and Authorizations (Back of Card) _____
Name of Primary Care Physician or Group Practice Name _____

Today's Date:_____Legal Name: _____

Age:_____Birthdate: _____

SS#:_____Marital Status: _____

Street Address:_____City:_____Zip: _____

Email for communicating to you: _____

Cell Phone for sending text messages: _____

Employer:_____Last Day Worked: _____

Spouse Name:_____Birthdate:_____Phone:_____
Street Address:_____City:_____Zip: _____

Primary Care Physician: _____
Name Phone Number Fax Number

_____
Address

Consent for Treatment

I hereby consent and agree to mental health 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 mental health provider directly supervising services rendered.

I understand (a) all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency/individual without my knowledge and consent (unless a release of information designee is appointed) except when required by law; (b) my provider is required by law to report knowledge of elder/child abuse or neglect; (c) my provider

must break confidentiality if there is serious intent to harm myself or another person; (d) **I understand that if I post anything to social media or request a third party entity to become involved in my care that I have by my own accord chosen to waive my confidentiality, and I authorize CNS, PC to share all of my protected information when necessary in order to appropriately respond to any social media or third party entities**.

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

Cancellation/No Show/Late Arrival Policy

I hereby consent and agree (a) insurance companies DO NOT COVER COST OF MISSED APPOINTMENTS; (b) I will be billed directly and held responsible for the **full cost of missed appointments (at the provider's billed rate) without a 24 hour notification**; (c) I acknowledge that if I am late to an appointment that CNS, PC will need to reschedule this appointment in consideration of other patients and the time necessary to appropriately complete the scheduled appointment; (d) I agree that this late arrival to an appointment will be considered a missed appointment without 24 hour notification, and that I will pay the full cost of the missed appointment.

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

Co-Pay Policy

Per our financial policy and contractual agreements with your health plan, you will be required to pay your office visit co-payment prior to seeing the doctor on the day of your visit. 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 will be added to your principal due to cover the transaction fee (see below)**. If you wish to avoid this fee, we recommend paying instead by check, cash, or money order.

I AGREE TO THE CO-PAY POLICY AND UNDERSTAND CARD PROCESSING FEES (INITIALS) _____

Fee Processing Consent

I hereby consent and agree (a) to authorize Carmel Neuropsychology Services, P.C. (CNS, P.C.) to bill my insurance carrier; (b) to release any information necessary to determine benefits and/or process claims to my insurance; (c) to authorize CNS, P.C. to utilize a photocopy of my signature to file with my insurance carrier; (d) to direct my insurance to issue payment/checks for services rendered by CNS, P.C.; (e) to reimburse CNS, P.C. for any insurance payments sent directly to me for services provided by CNS, P.C.; (f) **to pay co-payment at the beginning of each session**. **I agree to pay any residual balance on my account within 3 business days of my scheduled appointment. I understand that if I choose to pay by check that I will need to pay at least 8 business days before my scheduled appointment to ensure time for the banks to clear the checks**; (g) If I do not have insurance, payment must be made in full at the prior to or at the beginning of each session – whichever is directed by CNS, P.C.; (h) **failure to provide new insurance information will result in patient balance, and I will be directly responsible for the $100 reprocessing fee.** I understand that there will be a **$40 reprocessing fee for any insufficient check or credit card that requires reprocessing.**; (i) **I understand that payment is due at the time of service. I understand and agree that credit/debit cards will be applied a $5.00 Merchant fee for all balances at or below $200.00. For balances higher than $200.00 there will be a 4% processing fee from the Merchant**; (j) I am responsible for all service fees rendered to me and my family regardless of insurance benefits. I understand claims processed through my insurance carrier may be subject to copay, co-insurance, and/or deductible amounts per the policy I have selected with the insurance company. I understand that should a patient responsibility be applied, that these fees are not assessed by CNS, P.C. It is based on my insurance carrier and the policy/plan selected for my coverage. I understand that CNS, P.C. will seek prior authorization for services, and I understand that **my insurance company's authorization of services is not a guarantee of payment**; (k) I agree that in the unlikely event that my insurance company denies a claim or chooses to make no payment for the services provided, that I will be fully responsible for payment at my own expense for services rendered consistent with the providers billed rate. By signing and receiving services, I agree to these terms even though I am aware that I could potentially receive the same,similar, or alternate service from another provider potentially at no cost depending on how the insurance company chooses to process that claim. (l) **I understand that any unpaid balances more than 30 days past due may be turned over to a collection agency seeking repayment**; (m) I am responsible for all bad debt, collection fees and costs for me and my family members; (n) **I am aware that collection fees will be an additional 100% in addition to the**

principal balance due to cover attorney and collection costs; (o) I additionally agree to be fully responsible for any additional attorney or court fees for both myself and CNS, P.C. that may become due from processing the delinquent account; (o) and agree that I have read and understood the Neuropsychologist-Patient Service Agreement under the HIPPA tab on our website www.carmelneuro.com.

I UNDERSTAND THE FEES PROCESSING POLICIES AND UNDERSTAND THAT MY INSURANCE COMPANY IS RESPONSIBLE FOR PROCESSING CLAIMS. I UNDERSTAND THAT MY INSURANCE COMPANY MAY DELAY SERVICES OR DENY PAYING FOR SERVICES BASED ON THE POLICY I HAVE SELECTED WITH THEM. I AGREE TO PAY ANY PATIENT RESPONSIBILITY DUE IMMEDIATELY AND BE RESPONSIBLE FOR ANY LATE FEES OR COLLECTION FEES FOR MY UNPAID BILLS. (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 any establishment of functioning to be utilized in a legal setting (including establishment of disability), determination of capacity ("competency"), any involvement with attorneys or court system, or any involvement with probation or parole system.

I agree to inform CNS, PC **in advance of my initial appointment** of any current or pending legal proceedings, involvement in court or probation/parole system, or involvement in disability proceedings.

As a result, I understand and agree that if my case is determined **at any time** to be forensic in nature, then **forensic rates will be applied and based on time spent on the case**. This will be private pay, and we DO NOT bill through insurance. In the event that services have already been billed through insurance, I understand that CNS, P.C. will refund this money to my insurance, and I will be immediately responsible for the full forensic rates. **By signing and pursuing services with Carmel Neuropsychology Services, P.C., I will be fully responsible for payment at my own expense for services rendered consistent with the providers billed FORENSIC rate for any time spent on the case.**

I UNDERSTAND AND AGREE TO FORENSIC DETERMINATION FOR FEES. I AGREE TO BE FULLY RESPONSIBLE FOR SERVICES RENDERED IF MY CASE IS DETERMINED AT ANY TIME TO BE FORENSIC IN NATURE. (INITIALS) _____

Good Faith Estimate

I understand and agree that it is **my responsibility** (if I choose to do so) to contact members services at my insurance company and ask for them to process a **good faith estimate for potential services** under the insurance plan I have selected with my insurance company. I will provide the following CPT codes to my insurance company for them to review: 90791, 96116, 96132, 96133, 96136, 96137, and 90837. I understand that the good faith estimate and authorization of services is not a guarantee of payment but is based on the terms and conditions of the plan I have selected with my insurance company. I agree that CNS, P.C. is not indemnified for my patient responsibility determined by the insurance company or how my insurance company determines to process the claim. I understand and agree to the fees processing (subsection k as noted above) in the event that my insurance company denies payment on a claim or makes no payment for services rendered.

I UNDERSTAND AND AGREE TO THE GOOD FAITH ESTIMATE CLAUSE. I UNDERSTAND THAT THIS WILL BE DETERMINED BY MY INSURANCE COMPANY, AND I DO NOT INDEMNIFY CNS, P.C. FOR MY INSURANCE COMPANY'S GOOD FAITH ESTIMATE OR PROCESSING OF CLAIMS. (INITIALS) _____

Miscellaneous

(a) I hereby agree that if there is damage to CNS, PC property as a result of my or my family member's actions that I will be fully responsible for the replacement costs. I will pay this immediately.

Conduct

(a) 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. (b) If I make a mess or my family members makes

a mess in the office, I will clean it up. (c) I agree to keep my shoes and feet off of the furniture in the office. (d) I understand that CNS, PC has a **zero-tolerance** policy for profanity, verbal threats, harassment, or acts of violence of any kind. This includes: Actions taken or words conveyed with the purpose to intimidate, threaten, or harass; Using profanities or obscenities; Raising one's voice above an appropriate level; Personal attacks; Gesturing in a manner that causes one to fear for their safety; Invading, or remaining in one's personal space after being asked to move away; Physically blocking others from moving about freely; or 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. 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 Initial Appointment

(a) I agree that I will complete and return all forms as indicated in the instructions per HIPAA regulations **before an appointment will be offered**. These documents include: this patient agreement, the developmental history, previous medical records (optional), a release of information (optional – found under the contact section of the website), and any relevant legal forms or information. (b) I agree to come prepared with picture identification and insurance cards. Private pay patients must provide a picture identification. (c) I understand that if I arrive late to the appointment that CNS, PC has the right to reschedule this appointment in consideration of other patients and the time necessary to appropriately complete the scheduled service. (d) **I have reviewed the "what to expect" and "FAQ" section of the website to reduce any confusion and to fully understand how to proceed and what to expect.** (e) I understand that communication from the office will be provided in a written format due to the nature of patients the office sees. As a result, I will regularly check my email for important communications. 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 HAVE CAREFULLY READ **THE WEBSITE REGARDING WHAT TO EXPECT AND FREQUENTLY ASKED QUESTIONS**. I HAVE LOCATED THE MAP OF THE OFFICE LOCATION ON THE WEBSITE. I AM AWARE OF THE OFFICE CONTACT INFORMATION FOUND ON EACH PAGE OF THE WEBSITE. I AM AWARE THAT THE OFFICE IS **INSIDE THE BUILDING ON THE SECOND FLOOR.** I UNDERSTAND THE REASON FOR THE METHOD OF COMMUNICATION NOTED ABOVE AND AGREE. (INITIALS) _____

Preparation for Neuropsychological Testing and Results

(a) I agree to ensure that I will have adequate rest the night before the evaluation. (b) **If I am on medication that may compromise the testing results and if possible, I will work with my prescriber and CNS, PC to temporarily discontinue the medication during certain evaluation appointments in order to ensure the most accurate baseline of functioning** (c) I understand that it is my responsibility to provide my own snacks and drinks that are allowed during these longer evaluation sessions. (d) I understand and agree that significant delays in completing the evaluation process – whatever the cause – may necessitate repeating part or all of the process in order to ensure the most ethical and optimal results. (e) **I understand that the results will be disseminated at the feedback session. If I choose not to complete the evaluation process, there will be no results to share to myself or ROI designees.** (INITIALS) _____

I UNDERSTAND THAT THE RESULTS ARE TIME LIMITED AND APPLICABLE FOR NO MORE THAN THREE TO SIX MONTHS POST EVALUATION DUE TO THE NATURE OF BRAIN FUNCTIONING, GROWTH AND DEVELOPMENT, AND OTHER FACTORS THAT INFLUENCE COGNITIVE FUNCTIONING. (INITIALS) _____

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

_____ _____ _____

Patient Signature or Guardian Signature (if applicable) Guardian SS# Guardian DOB

_____ _____

Patient or Guardian Name (if applicable) Date

PLEASE RETURN THIS COMPLETED FORM TO EMAIL OR ADDRESS IN HEADER

This agreement will be attached to your chart. A copy is available upon request.