Carmel Neuropsychology Services, P.C.

755 West Carmel Drive, Suite 205
Carmel, IN 46032
317-610-0166 (fax) 317-571-0088 CNS@CarmelNeuro.com www.CarmelNeuro.com

Minor Intake Sheet

(Skip the bulleted section if you are private pay)

- 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: ___/___/_____ Child's Legal Name: _____
Age: _____ Birthdate: ___/___/_____ School:_____ Grade:_____
Address: _____
Number Street City Zip Code
SS# _____
Home Phone: _____ May we leave a message at this number with our name? _____
Work Phone: _____ May we leave a message at this number with our name? _____
Cell Phone: _____ May we leave a message at this number with our name? _____

Legal Guardian's Name (and address if different):
_____
_____
Number Street City Zip Code

Guardian's Birthdate: __/__/__ _____ SS# _____
Parent's Name (and address if different): _____
_____
Number Street City Zip Code
Previous Professional Help: _____ If Yes, Professional's Name: _____
Location: _____ Date Last Seen: _____
Primary Care Physician: _____
Name Phone Number Fax Number
_____
Address
Medications: _____
_____
_____
Medication Allergies: _____
Siblings' Names Birthdate Address Other Info.
_____
_____
_____

Consent for Treatment for Minor Patients

I, _____ , being the parent (_____) or legal guardian (_____), for my son or daughter, _____, hereby consent and agree to his/her mental health treatment at Carmel Neuropsychology Services, P.C. within (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 except when required by law; (b) my therapist is required by law to report knowledge of elder/child abuse or neglect; (c) my therapist must break confidentiality if there is serious intent to harm myself or another person.

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 without a 24 hour notification; (c) I acknowledge that if I am late to an appointment without timely notification of CNS, PC that CNS, PC reserved the right to reschedule this appointment in consideration of other patients; (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.

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, 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. If you wish to avoid this fee, we recommend paying instead by check, cash, or money order.

Fee Processing Consent

I hereby consent and agree (a) to authorize Carmel Neuropsychology Services, 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 Carmel Neuropsychology Services, 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 Carmel Neuropsychology Services, P.C.; (e) to reimburse Carmel Neuropsychology Services, P.C. for any insurance payments sent directly to me for services provided by Carmel Neuropsychology Services, P.C. In the event that my insurance company pays nothing for a claim or deems the claim as not medically necessary, I agree to pay Carmel Neuropsychology Services, P.C. in full for the service provided and received; (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 beginning of each session; (h) failure to provide new insurance information will result in patient balance, and I will be directly responsible for the $100 reprocessing fee; (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 Carmel Neuropsychology Services, P.C. It is based on my insurance carrier and the policy/plan selected for my coverage. I understand that Carmel Neuropsychology Services, 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 understand that any unpaid balances more than 30 days past due may be turned over to a collection agency seeking repayment; (l) I am responsible for all bad debt, collection fees and costs for me and my family members; (m) I am aware that collection fees may be up to an additional 100% in addition to the principal balance due; (n) I additionally agree to be fully responsible for any attorney or court fees for both myself and Carmel Neuropsychology Services, 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.

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. 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. 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 as documented above under the fee for service section above. Forensic cases include but are not limited to any establishment of functioning to be utilized in a legal setting (including establishment of disability), any involvement with attorneys or court system, or any involvement with probation or parole system.

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. (b) I understand that if I am not present to pick up my child, CNS, PC is not responsible for unattended children. (c) If my child is in potential danger if left alone due to age, cognitive ability, disability, etc., and I do not show in a timely manner to pick up my child I will fully compensate CNS, PC at the hourly rate ($250) for time spent with my child until they can be safely released to my custody.

Conduct

(a) I hereby agree to be responsible for 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 my child is disruptive. Additionally, I agree to silence cell phones or electronic devices and step outside for phone conversations. (b) If I make a mess or my child 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 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. Most people respect and follow these guidelines for comportment. By signing this document, I agree to be one of them.**

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. (b) I agree to come prepared with picture identification and insurance cards. (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. (d) 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. I understand that these situations warrant forensic/legal fees which will be billed directly to me and not through my insurance company.

Preparation for Neuropsychological Testing

(a) I agree to ensure that my child has adequate rest the night before the evaluation. (b) If my child is on medication that may compromise the testing results, I will work with the 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 agree to help my child obtain the most accurate results by ensuring that he or she is properly fed and hydrated. It is my responsibility to provide these snacks and drinks that are allowed during these sessions. I agree to not provide overly sugared or caffeinated food or beverages. (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.

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.

I HAVE CAREFULLY READ THE INFORMATION IN THIS AGREEMENT AND ON THE WEBSITE REGARDING WHAT TO EXPECT AND FREQUENTLY ASKED QUESTIONS.

I HAVE READ, UNDERSTAND AND AGREE TO BE LEGALLY BOUND TO THE FOREGOING.

_____ _____

Parent or Guardian Signature Date Signed

_____ _____

Witness Signature Date Signed

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