LANDSTROM CENTER

NEW CLIENT REGISTRATION

Neuropsychological Evaluation

We are excited to have you as a client and ask that you
complete these intake forms prior to your first appointment.
Please reach out with any questions, and we look forward to meeting you.

Patient Information

PATIENT'S FULL NAME: _____

CONTACT INFORMATION

Mailing address: _____

Home phone number: _____ Cell phone number: _____

Email address: _____

What form of communication do you prefer?: ☐ *Email.* ☐ *Phone.*

PERSONAL INFORMATION

Sex: _____ Date of birth: _____ Social Security Number: _____

Relationship status: _____

REFERRAL SOURCE

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone number: _____

PERSON COMPLETING THIS FORM

Is the patient the person completing this form? ☐ *Yes.* ☐ *No.*

If not, please provide:

Your name: _____ Relationship to patient: _____

EVALUATION

Have you (or your child) had an evaluation? ☐ *Yes.* ☐ *No.*

If yes, where?: _____

How We Will Contact You

Do we have permission to send mail to your home? ☐ *Yes.* ☐ *No.*

If *no*, please provide an address (may be a P.O. box) where we *can* send you mail:

Street address: _____

City: _____ State: _____ Zip: _____

If it is not your home, whose address is this? _____

Do we have permission to leave a voicemail on your phone? ☐ *Yes.* ☐ *No.*

If yes, which phone(s)?: ☐ *Home.* ☐ *Cell.*

When we will call you: *To best serve your mental health needs, Landstrom Center will confirm your appointment one business day in advance. Your therapist/psychologist will also return your call/message if they are not available when you call, and may leave a message with information you requested regarding your treatment.*

Initial: _____ *I have read and understand this, and I consent to receive calls.*

Do we have permission to email you? ☐ *Yes.* ☐ *No.*

When we will email you: *If you consent to correspond with Landstrom Center via email, you acknowledge that email is not a secure form of communication and that its confidentiality cannot be ensured. Landstrom Center may email you to confirm/schedule appointments, to convey information about your treatment, or to provide records that you have requested.*

Initial: _____ *I have read and understand this, and I consent to receive emails*

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LANDSTROM CENTER

NEW CLIENT REGISTRATION

Neuropsychological Evaluation

Billing Information and Policies

FEE SCHEDULE

• Diagnostic Interview..... *(with initial treatment plan)*	$220 / hour
• Psychological and Neuropsychological Assessment..... *(includes evaluation report)*	$220 / hour
• Feedback Session and Consultation.....	$200 / hour
• Letter Writing and Document Preparation..... *(additional documentation beyond evaluation report)*	$35 / 15 min
• Psychotherapy.....	$200 / hour
• Neurofeedback.....	$150 / session
• Forensic Examination.....	$350 / hour
• Deposition and Testimony.....	$500 / hour
• IEP / School Observations / School Staffings..... *(portal to portal; includes file review and preparation time)*	$35 / 15 min

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DIVORCE AND CUSTODY POLICY (If completing this form for a child, please initial)

I understand that in the case of a divorce or custody agreement, as the signer of this form I am taking responsibility for the full balance for services rendered. I will need to independently seek restitution from the other parent or guardian for their percentage of the medical costs per the custody agreement. Payment is due at time of service, regardless of who brings the child to the appointment.

Initial: _____ I understand and agree to be bound by this policy.

CANCELLATION POLICY

If you need to cancel or reschedule your appointment, you may do so at least 24 hours before your scheduled appointment. You may cancel or reschedule by calling the number on this form (you may leave a message). If you cancel within 24 hours of your scheduled appointment time, you will be charged a missed appointment fee of $50.00 per hour of scheduled time. Your insurance company will not cover this charge.

Initial: _____ I understand and agree to be bound by this policy.

DO YOU WANT US TO BILL YOUR INSURANCE? ☐ *Yes.* ☐ *No.*

IF YOU DO WANT YOUR INSURANCE BILLED, PLEASE COMPLETE THIS SECTION:

Insurance company name: _____

ID #: _____ Group number: _____

Insured's name: _____ Relationship to patient: _____

Insured's date of birth: _____ Insured's phone number: _____

Insured's address: ☐ *Same as patient.* _____

INSURANCE ACKNOWLEDGMENTS

No Guarantee of Benefits: If we are in-network for your health plan, we will bill your health insurance company directly for our services. Verifying your insurance coverage and benefits is *your* responsibility. If we are out-of-network with your plan but you have out-of-network health insurance coverage, upon your request, we will provide the documentation necessary so that you may submit a claim to your insurer. You are responsible for paying any amount that your insurance company does not pay, which may be 100% of our fees.

Initial: _____ I understand this billing policy, and I agree to be bound by it.

...

Contracted Rate: If your provider is in-network with your insurance, s/he has agreed to a rate with your insurance company. Your provider cannot charge you for the difference between the fees listed in our Fee Schedule and the fee covered by your insurance. *You will always be responsible for the co-pay and/or any deductible amount required by your insurance.*

Initial: _____ I understand this policy, and I agree to be bound by it.

...

Testing Fee: Landstrom Center's $50.00 testing fee will not be covered by your insurance. It will cover the costs of testing materials/protocols, transcription of the report, etc.

Initial: _____ I understand that I am responsible for the testing fee.

IF YOU DO NOT WANT YOUR INSURANCE BILLED, PLEASE COMPLETE THIS SECTION:

☐ I am uninsured. ☐ I have insurance, but I do not want them to be billed.

SELF-PAY ACKNOWLEDGMENT

If you do not have insurance or you do not want Landstrom Center to bill your insurance for our fees, you may pay us directly at the time of service. This means that payment is due at the time of your appointment. Landstrom Center has not collected or verified your insurance information, and we thus do not guarantee that you can receive partial reimbursement from any third-party for our fees.

(Continued on next page)

If you later decide to file claims for reimbursement with your insurance company, it may not cover these services, or it may consider them to be out-of-network. If you decide to do this, we will provide the documentation necessary so long as you request that documentation within 6 months of the date of the appointment to which it pertains.

Initial: _____ I have read and understand this billing policy, and I agree to be bound by it. I understand that I am ultimately responsible for all charges I incur.

I have read Landstrom Center's billing policies and fee structure. I understand and agree to be bound by these policies.

_____ _____

Patient Signature Date

Informed Consent to Psychological Evaluation

I, _____, acknowledge that Landstrom Center, its owners, agents, or employees will take part in a psychological evaluation with me.

I acknowledge that the ideas, goals, and methods of the evaluation process have been explained to me, and Landstrom Center will only use procedures that are appropriate for my age, ethnicity, gender, and differential diagnosis.

I further acknowledge that the purpose of the evaluation is to provide diagnostic clarity so that empirically validated treatment can be tailored to my needs, and the results, interpretations, diagnoses, and resulting treatment plan will only be as accurate as I am willing to fully engage in the evaluation process.

I further acknowledge that I have the right to withdraw from participation at any time, but there may be adverse consequences for my refusal to cooperate.
I further acknowledge that:

- The evaluation and its risks, benefits, side effects, and alternatives have been explained to me;
- The evaluation may not have the result that I expect, and I have been informed as to other possible treatments that may provide me a benefit;
- I have not been given any guarantees about the result of any evaluation;
- I have had ample opportunity and time to discuss my concerns with Landstrom Center or any healthcare provider that I desire, and all my questions have been answered to my satisfaction.
- I have been provided with Rights and Responsibilities of Test Takers.

By signing below, I acknowledge that I am competent, understand this policy, and have been provided material information regarding the proposed care, treatment, service, intervention, or procedure, and the anticipated risks, benefits, side effects, and alternatives, as well as the risks of non-treatment. Thus, I hereby provide my informed consent to receive the Treatment as described in this document.

_____ _____
Patient's Signature Date

I have discussed this acknowledgment with this patient. My observations of this patient's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Clinician Signature Date

Authorization for Use or Disclosure of Protected Health Information for Payment and Insurance Claims Processing Purposes

I, _____, voluntarily authorize Landstrom Center's disclosure and use of my protected health information contained in *(check one)* ☐ my health record, or ☐ my dependent's health record. and other private information to the extent necessary for Landstrom Center to obtain payment and submit claims on my behalf to my insurance company or other third-party payor.

The following information cannot be disclosed without your express authorization. I hereby expressly authorize the below information:

☐ Yes	☐ No	Alcohol & Drug Use
☐ Yes	☐ No	Sexually Transmitted Diseases
☐ Yes	☐ No	HIV/AIDS-related Treatment
☐ Yes	☐ No	Mental Health
☐ Yes	☐ No	Psychotherapy Notes*
☐ Yes	☐ No	Treatment/Referral/Consultation Information

**Disclosing your psychotherapy notes may waive the psychotherapist-patient privilege.*

AGREEMENTS & ACKNOWLEDGEMENTS

I agree and acknowledge that:

_____ I may revoke this authorization by providing written notice to Landstrom Center, except to the extent that action has been taken in reliance upon it. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I provide an alternate date, or until Landstrom Center has been paid for all services, whichever is longer. *Expiration date:* _____

_____ Information disclosed pursuant to this authorization, except for alcohol and drug abuse (as defined in 42 CFR part 2) and mental health records, may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I hereby authorize:

_____ My insurance company, or other third party payor to make payments directly to Landstrom Center and assign Landstrom Center any medical benefits to which I may be entitled, including any benefit under Employee Retirement Income Security Act of 1974 (ERISA) in consideration for the services provided.

_____ Landstrom Center to communicate with the primary insured and release the information as necessary to facilitate payment if I am not the primary beneficiary of the above insurer or third-party payer.

SIGNATURE OF PARTY AUTHORIZING RELEASE

You may revoke this authorization at any time by providing written notice to Landstrom Center. Landstrom Center will retain the completed, signed form for its records.

_____
Patient Printed Name

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (for dependent patients) Date

_____ _____
Witness Signature, Landstrom Center Date

Page 2 of 2 of Payment Release. Do not separate from page 2.

Authorization for Use or Disclosure of Protected Health Information for Coordination of Care Purposes

I, _____, voluntarily authorize Landstrom Center's disclosure and use of my protected health information contained in *(check one)* ☐ my health record, or ☐ my dependent's health record. and other private information (including any reports) to the extent necessary to coordinate care with my primary care physician, psychiatrist, counselor, therapist, or school.

This information may be disclosed to:

Provider Name: Practice Name: Specialty:	Phone: Fax:
Provider Name: Practice Name: Specialty:	Phone: Fax:
Provider Name: Practice Name: Specialty:	Phone: Fax:
Provider Name: Practice Name: Specialty:	Phone: Fax:

I consent to the disclosure of the following:

- ☐ Only information related to: _____
- ☐ Only information for these dates: _____
- ☐ Other: _____
- ☐ My entire record (items below will be excluded unless expressly authorized)

The following information cannot be disclosed without your express authorization.

I hereby expressly authorize the below information:

☐ Yes	☐ No	Alcohol & Drug Use
☐ Yes	☐ No	Sexually Transmitted Diseases
☐ Yes	☐ No	HIV/AIDS-related Treatment
☐ Yes	☐ No	Mental Health
☐ Yes	☐ No	Psychotherapy Notes*
☐ Yes	☐ No	Treatment/Referral/Consultation Information

**Disclosing your psychotherapy notes may waive the psychotherapist-patient privilege.*

Page 1 of 2 of Coordination of Care Release. Do not separate from page 2.

AGREEMENTS & ACKNOWLEDGEMENTS

I agree and acknowledge that:

_____ I may revoke this authorization by providing written notice to Landstrom Center, except to the extent that action has been taken in reliance upon it. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I provide an alternate date. *Expiration date:* _____

_____ Information disclosed pursuant to this authorization, except for alcohol and drug abuse (as defined in 42 CFR part 2) and mental health records, may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I hereby authorize:

_____ Landstrom Center to communicate with the providers identified herein as necessary to facilitate the coordination of my care.

SIGNATURE OF PARTY AUTHORIZING RELEASE

You may revoke this authorization at any time by providing written notice to Landstrom Center. Landstrom Center will retain the completed, signed form for its records.

_____
Patient Printed Name

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (for dependent patients) Date

_____ _____
Witness Signature, Landstrom Center Date

Page 2 of 2 of Coordination of Care Release. Do not separate from page 2.

Graduate Student Participation in Treatment Authorization

Our licensed clinical neuropsychologists provide training and supervision to graduate students, who are enrolled in a doctoral clinical psychology program. This means, that a graduate student may participate or observe your intake and feedback sessions and score, administrate, or help with portions of your evaluation. *However, all diagnostic impressions, treatment planning, and consultations with physicians will be completed by a supervising licensed neuropsychologist.*

SIGNATURE OF PARTY AUTHORIZING RELEASE

You have the right to refuse graduate student participation in or observation of treatment without penalty. You may revoke this authorization without penalty at any time by providing us written notice.

By signing below, I authorize student participation in or observation of my (or my dependent's) treatment as described above.

_____

Patient Printed Name

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (for dependent patients) Date

_____ _____

Witness Signature, Landstrom Center Date

Graduate Student Participation in Treatment Authorization.

Test Taker's Rights and Responsibilities

As a test taker, you have the right to:

1. Be informed of your rights and responsibilities as a test taker.
2. Be treated with courtesy, respect, and impartiality, regardless of your age, disability, ethnicity, gender, national origin, religion, sexual orientation or other personal characteristics.
3. Be tested with measures that meet professional standards and that are appropriate, given the manner in which the test results will be used.
4. Receive a brief oral or written explanation prior to testing about the purpose(s) for testing, the kind(s) of tests to be used, if the results will be reported to you or to others, and the planned use(s) of the results. If you have a disability, you have the right to inquire and receive information about testing accommodations. If you have difficulty in comprehending the language of the test, you have a right to know in advance of testing whether any accommodations may be available to you.
5. Know in advance of testing when the test will be administered, if and when test results will be available to you, and if there is a fee for testing services that you are expected to pay.
6. Have your test administered and your test results interpreted by appropriately trained individuals who follow professional codes of ethics.
7. Know if a test is optional and learn of the consequences of taking or not taking the test, fully completing the test, or canceling the scores. You may need to ask questions to learn these consequences.
8. Receive a written or oral explanation of your test results within a reasonable amount of time after testing and in commonly understood terms.
9. Have your test results kept confidential to the extent allowed by law.
10. Present concerns about the testing process or your results and receive information about procedures that will be used to address such concerns.

As a test taker, you have the responsibility to:

1. Read and/or listen to your rights and responsibilities as a test taker.
2. Treat others with courtesy and respect during the testing process.
3. Ask questions prior to testing if you are uncertain about why the test is being given, how it will be given, what you will be asked to do, and what will be done with the results.
4. Read or listen to descriptive information in advance of testing and listen carefully to all test instructions. You should inform an examiner in advance of testing if you wish to receive a testing accommodation or if you have a physical condition or illness that may interfere with your performance on the test. If you have difficulty comprehending the language of the test, it is your responsibility to inform an examiner.

5. Know when and where the test will be given, pay for the test if required, appear on time with any required materials, and be ready to be tested.
6. Follow the test instructions you are given and represent yourself honestly during the testing.
7. Be familiar with and accept the consequences of not taking the test, should you choose not to take the test.
8. Inform appropriate person(s), as specified to you by the organization responsible for testing, if you believe that testing conditions affected your results.
9. Ask about the confidentiality of your test results, if this aspect concerns you.
10. Present concerns about the testing process or results in a timely, respectful way, if you have any.

Notice of Privacy Practices

Landstrom Neuropsychological Center, P.C.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Patient Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Patient Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information

Our Uses and Disclosures

Landstrom Center may use and share your information as we:

- Treat you
- Run our practice
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Patient Rights: In Detail

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities.

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (called an "accounting") of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Patient Choices: In Detail

You can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care, share information in a disaster relief situation, and include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission: Marketing purposes, sale of your information, and most sharing of psychotherapy notes

Uses & Disclosures of Landstrom Center

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you. We can use your health information and share it with other professionals who are treating you.
Operate our practice. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues.

We can share health information about you for certain situations such as: Preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and preventing or reducing a serious threat to anyone's health or safety.

LANDSTROM CENTER

Do research.

We can use or share your information for health research.

Comply with the law.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests.

We can share health information about you with organ procurement organizations.

Address workers' compensation, law enforcement, and other government requests.

We can use or share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions.

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Responsibilities of Landstrom Center

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Other Information About This Notice

- This notice is effective on (date): June 1, 2017
- Chief Privacy Officer is (name): Kim Skierkiewicz
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

LANDSTROM CENTER