NeuroPsych Center Of Greater Cincinnati

Patient Registration

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary # to leave a message: _____

Home #: _____ Cell #: _____ Work #: _____

Birthdate: _____ ☐ M or ☐ F Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Email Address (if available): _____

Employer Name: _____

Primary Care Physician: _____ Phone #: _____

Primary Care Physician Address: _____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

Insurance Information

Primary Ins. Name: _____ Secondary Ins. Name: _____

ID#: _____ ID#: _____

Policyholder Information ☐ **Information same as patient**

Primary Policyholder

Name: _____

Address: _____

City: _____

Home #: _____

DOB: _____SS#: _____

Secondary Policyholder

Name: _____

Address: _____

City: _____

Home #: _____

DOB: _____ SS#: _____

Responsible Party ☐ **Patient** ☐ **Policy Holder** ☐ **Other** (provide info below)

Are we able to contact this person regarding payment and billing information? ☐ Yes ☐ No

Name: _____ DOB: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

SSN: _____

Emergency Contact

Name: _____ Relationship: _____

Primary contact# _____ Secondary contact # _____

NeuroPsych Center Of Greater Cincinnati

Name: _____ DOB: _____ Date: _____

DO YOU HAVE ANY PHYSICAL IMPAIRMENTS OR LIMITATIONS WHICH MAY REQUIRE SPECIAL ACCOMMODATIONS, SPECIAL ARRANGEMENTS, OR MAY AFFECT YOUR TREATMENT (i.e., reading difficulties, hearing loss, vision loss, speech impairment)? ☐ Yes ☐ No

If yes, please explain: _____

Briefly describe why you are seeking an evaluation

_____

_____

_____

HEALTH HISTORY:

Primary Care Physician: _____ Phone #: _____

Do you have any drug allergies? ☐ Yes ☐ No If yes, please specify: _____

Do you have any physical health problem(s)? ☐ Yes ☐ No If yes, what condition(s):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List any surgeries, hospitalizations, or significant post health issues: _____

_____

History of traumatic brain injury? ☐ Yes ☐ No If yes, please specify: _____

_____

Tobacco Product Use? ☐ Current ☐ Past ☐ Never Used Packs per day: _____

Other Tobacco Product Use: _____

Weight change in the past 6 months: ☐ Yes ☐ No Amount: _____

Significant appetite changes over the past month: ☐ Yes ☐ No

How healthy is your diet? ☐ Excellent ☐ Good ☐ Poor

Do you currently follow a special diet or nutritional program? _____

Caffeine intake: ☐ Yes ☐ No If yes, how much? _____

Pop/Soda intake: ☐ Yes ☐ No If yes, how much? _____

Do you exercise? ☐ Yes ☐ No

Rate your level of motivation to include exercise in your life. ☐ Low ☐ Medium ☐ High

How many hours of sleep do you get each night on average? _____

Do you have trouble falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

How much trouble? _____

NeuroPsych Center Of Greater Cincinnati

Are you currently on any physician-prescribed medications or regularly take any "over the counter" medication, including any prescriptions for anxiety, depression, or other mental conditions?
☐ Yes ☐ No

If yes, please specify the Medication(s) below:

Medication/Purpose	Dosage / Times Per Day	How Long?	Do you take this medication consistently?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List any past psychiatric medications and the outcome: _____

_____

_____

SPIRITUAL:

Cultural/ethnic/racial issues that need consideration: _____

Sexual orientation issues that need consideration: _____

Religious/spiritual issues that need consideration: _____

EDUCATIONAL BACKGROUND:

Highest Level of Education Achieved: _____ Grades: ☐ Above Ave. ☐ Average ☐ Below

If Dropped Out, Why? _____

Vocational Skills/Training: _____

MARITAL HISTORY:

Current Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____ Age: _____ Years Married: _____

Describe the general quality of the relationship: _____

_____

EMPLOYMENT BACKGROUND:

Prior Employers and Positions: _____

_____

If NOT Employed (select one): ☐ Student ☐ Homemaker ☐ Disabled ☐ Unemployed ☐ Retired

MILITARY HISTORY:

Dates of Service: _____ Highest Rank Achieved: _____

Type of Discharge: _____

Any Significant Influence on Current Functioning: _____

_____

NeuroPsych Center Of Greater Cincinnati

LEGAL HISTORY:

Describe: _____

_____

Applying for disability? ☐ Yes ☐ No If yes, please explain: _____

MENTAL HEALTH (if applicable):

Have you had prior mental health services, counseling, or alcohol/drug treatment? ☐ Yes ☐ No

If yes, please list names and dates below:

OUTPATIENT		**INPATIENT**	
Provider or Program Name	Dates	Hospital	Dates

For what problems have you sought out help? _____

_____

Outcome(s) of past treatment: _____

_____

Are you having any memory problems, trouble thinking, or disorientation? ☐ Yes ☐ No

If yes, please explain: _____

Is there any history of emotional or mental problems in the family? ☐ Yes ☐ No

If yes, please explain: _____

History of any suicidal or self-injurious behavior? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you have any current or past alcohol or other substance use? ☐ Yes ☐ No

If yes, please explain: _____

_____

Has anyone in your family had problems with alcohol or other substance use? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you have any history of traumatic events? ☐ Sexual abuse ☐ Domestic violence

☐ Physical abuse ☐ Rape/sexual assault ☐ Emotional abuse ☐ Other significant trauma

Please comment: _____

_____

_____

NeuroPsych Center Of Greater Cincinnati

Consent to Treat

Name: _____ DOB: _____

I hereby certify that The NeuroPsych Center of Greater Cincinnati clinician providing services has informed me of their professional qualifications, certifications, and/or licensure; has provided both an explanation and a copy of client's rights and responsibilities; and has informed me of their assessment, diagnosis, and treatment plan. By signing below, I agree to participate in the proposed treatment as recommended by the undersigned NCGC clinician and that information concerning my treatment may be shared with other NCGC clinicians should it be deemed useful to my treatment.

Further, I understand that The NeuroPsych Center of Greater Cincinnati currently uses electronic medical records for provider-to-provider communication and storage of any and all medical information. Electronic medical records allow access to electronic databases for additional information concerning both present and past medications and treatment.

_____ _____

Patient/Guardian Signature Date Clinician Signature Date

Consent to Release Patient Information to Primary Care Physician and Coordinate Care

(PLEASE CHECK A BOX BELOW)

☐ I **do not** have a primary care provider.
☐ I **do not** wish my primary care provider to be contacted at this time.
☐ I authorize The NeuroPsych Center of Greater Cincinnati to contact my primary care physician:

Physician Name: _____

Phone Number: _____

Street Address: _____

City, State and Zip: _____

To provide information regarding my treatment, diagnosis, behavioral, mental and emotional functioning, and behavioral health status.

_____ _____

Patient/Guardian Signature Date Clinician Signature Date

NeuroPsych Center Of Greater Cincinnati

OHIO 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

NCGC may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes in most instances without your *consent under HIPAA, but we obtain consent in another form*. 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 therapist.
  - *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, which would include an audit.
  - *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 practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our practice group, 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 a written 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. Note, psychotherapy notes may not be required to be released for eligibility or underwriting purposes.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization as allowed by law, including, but not necessarily limited to, the following circumstances:

- **Child Abuse:** If, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or mentally retarded/developmentally disabled child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or other appropriate governmental agency.
- **Adult and Domestic Violence:** If we have reasonable cause to believe that an elderly adult age 60 or over, or an adult mentally retarded/developmentally disabled person is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services and/or other appropriate government agency. If we believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient's or client's records.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from you or your personal or legally-appointed representative, or upon receipt of 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:** If we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b)

your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances.

Worker's Compensation: If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials. IV. Patient's Rights and NCGC'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, except under certain limited circumstances.
- *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 one of us, so you may not want us calling your home and leaving a message on an answer machine. Upon your request, we will send your bills to another address and/or place calls to another number. If your request is reasonable, then we will honor it.
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record.
- *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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process. This does not apply to any time prior to April 17, 2003, and the accounting is only required to be kept for a six year period.
- *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.

NEUROPSYCH CENTER OF GREATER CINCINNATI'S DUTIES:

- We are required by law to maintain the privacy of PHI and to provide you with this 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 and to make those changes effective for all of the PHI we maintain.
- If we revise our policies and procedures, we will make available a copy of the revised notice to you on our website and you may always request a paper copy.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may file a complaint with us and we'll consider how best to

resolve your complaint. Contact our Privacy Officer, listed below, if you wish to file a complaint with us. In the event that you aren't satisfied with our response to your complaint, or don't want to first file a complaint with us, then you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or to:

Region V, Office for Civil Rights

U.S. Department of Health and Human Services

233 N. Michigan Ave., Suite 240

Chicago, IL 60601. Ph. (312) 886-2359, Fax (312) 886-1807, TDD (312) 353-5693.

-There will be no retaliation against you for filing a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on March 31, 2006.

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 make available a copy of the latest version on our website, or, upon your request, we will provide it in writing to you via U.S. mail. .

VII. PRIVACY OFFICER

The Privacy Officer for NeuroPsych Center of Greater is Babu Gupta, M.D., 4015 Executive Park Drive, Suite 320, Cincinnati, OH 45241, 513-563-0488. You may contact him if you have any questions about any Privacy Policies or if you wish to file a complaint with the practice.

ACKNOWLEDGEMENT OF NCGS' NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have read and been offered a copy of NCGC'S Notice of Privacy Practices in accordance with current HIPAA regulations.

Patient Name	*Patient/Guardian Signature*	*Date*

NeuroPsych Center of Greater Cincinnati must verify the identity and authority of a personal representative or list attempts that were made to obtain a signature and distribute the form to the client.

NeuroPsych Center Of Greater Cincinnati

FEES FOR INDIRECT SERVICES

At NeuroPsych Center of Greater Cincinnati, our goal is to provide you with high-quality and cost-effective mental health care. We believe that your needs are best met during office visits, when we can listen to your concerns and discuss your plan of care directly with you. Please take the time to review fees for services that we may provide outside of, or in addition to, your office visit. If there is a hardship, fees may be waived.

Fee Structure for non-office visit services by providers:

- Please note that simple phone contacts or short letters/forms requiring a few minutes of provider time will not be charged to you.
- **Phone Consult**: If you have a serious problem that you need to discuss with your provider between visits, the charge will be **$45 per each 15 minutes** of time required. This same fee may be charged for phone calls made on your behalf to discuss and/or coordinate your care and treatment with non-NCGC providers.
- **Letters and Forms:** Such services may include but are not limited to the following: forms or reports required by disability insurance companies, treatment summaries or letters to physicians, schools or non-NCGC providers. The charge will be **$45 per each 15 minutes** of time required. Please note that **a minimum of 10 working days is necessary in order to provide adequate time for completion of such paperwork.**
- **Medication Refills: $15** per call for refills when you miss an office visit or do not schedule a visit in a timely manner.

Prior Authorization: A **$20** fee for time spent on each medication requiring a provider to obtain a prior authorization from your insurance company.

What YOU can do to help avoid out-of-office charges:

- Schedule your next office visit with your provider well in advance
- Keep your scheduled appointment with your provider
- Keep track of when you will need refills, and bring this list with you to your office visits with the providers who prescribe your medicines
- Keep track of where you place written prescriptions
- Take your medicines as directed

What WE will do to help keep your costs as low as possible:

- Order generic substitutions whenever medically appropriate
- Complete mail order prescriptions when medically appropriate
- Provide you with enough refills to cover your needs between office visits when this can be safely done
- When a new medicine is ordered, we will try to give you a trial supply of samples or provide you with a manufacturer voucher
- Occasionally, we can provide you with samples at other times, but this is not something that you or we can count on being able to do regularly.

Patient: _____ **DOB:** _____

I have read and understand the Office Policies of NeuroPsych Center of Greater Cincinnati not covered by insurance.

_____ _____

Patient/Guardian Signature **Date**

NeuroPsych Center Of Greater Cincinnati

CLIENT RIGHTS

TREATMENT INPUT/PARTICIPATION: Since you are an integral part of your treatment, you have the right to ask questions at any point. You may request and negotiate therapeutic goals, and you may refuse to participate in any intervention, strategy or behavior suggested by your therapist. You have the right to be fully informed regarding the therapist's estimation of approximate length of therapy to meet your agreed upon goals. You have the right to terminate treatment at any time. A termination session may be suggested in order to discuss progress made or continuing areas of concern. If you wish to continue treatment with one of our clinicians but feel you need a different approach or clinical orientation, you may request a change of therapist by discussing this with your current therapist or contacting our Clinical Director at 513-563-0488. Every effort will be made to satisfy your request. You have the right to be fully informed about your therapist's qualifications, training and experience and you may ask questions about his/her clinical orientation.

FINANCIAL AND BILLING POLICY

SELF-PAY PATIENTS: **SELF-PAY PATIENTS:** Our fee for an initial therapy assessment is $225. All therapy follow-up appointments are $175. Our fee for a diagnostic assessment for medication management is $300.00. All Follow-up for medication management will be $150.00. If follow-up fees are paid at the time of services a 25% discount will be applied, there is no discount for initial assessments. Psychological evaluations, testing, and reports are billed at a rate of $225 per hour, and this fee will be discussed in advance with the client. Ancillary professional services are charged at a rate of $300 per hour and are not to be covered/reimbursed by insurance (e.g., consultation with other professionals or agencies, court appearances, depositions, subpoenas, preparation of reports and case related correspondence, telephone calls, etc.)

CO-PAY/DEDUCTIBLES: It is the patient's responsibility to know what their co-pay is and their obligation to pay at the time of service. If the co-pay is not paid at the time of service, the appointment may be rescheduled, and a $5.00 fee will be applied to your account. If you are not the responsible party and the person responsible for the amount owed will not be accompanying, you at each visit please speak to the front desk about putting a credit card on file to be charged at each visit for the amount owed. NCGC will propose a suggested amount to be paid toward the patient's deductible so one does not accrue a balance and become subject to a fee. If you have health insurance, please understand that these amounts owed are an agreement between you and your insurance company.

PAST DUE ACCOUNTS: All accounts are considered past due if not paid within 30 days of patient responsibility date. A $5.00 fee will be assessed to your account after the 30-day period if a balance is not paid. Balances over $200 are subject to the refusal of future appointments and/or refills until paid. Past due accounts 90 days or later may result in the account being referred to an outside collection agency and may be subject to dismissal from the practice.

INSURANCE COVERAGE: It is the patient's responsibility to present their current insurance cards at each visit. If they do not have their cards with them at the time of service, they will be responsible for all charges incurred. If the insurance card is presented after services are rendered, but not within the filing limit for the payer, the patient will be responsible for all charges.

PARTICIPATING INSURANCE PLANS: If NCGC is not a participating provider for your insurance plan, we will file the claims for you, but you will be responsible for paying the balance due on your account in full within 30 days.

REFERRALS & AUTHORIZATIONS: Some insurance plans require you to obtain a referral for services by a specialist, please review your policy to see if a referral is required prior to your visit with our office. If your referral is not on file at the time of your visit, you may be asked to reschedule your appointment, or you will be responsible for all charges incurred. If your insurance company requires an authorization for your initial visit(s), please make sure that you have obtained this authorization no later than your first visit. If your insurance company denies your initial visit(s) because of no authorization you will be responsible for full payment for these visit(s).

RETURNED CHECKS: A $30 fee will be charged for returned checks. We may use electronic withdrawal from your account for the amount of the check plus the $30 returned check fee, if a check is returned for insufficient funds.

NO SHOW/LATE CANCEL APPOINTMENTS: Appointments that are not cancelled within 24 hours of the appointment time may be subject to a $75 no show or late cancel fee. These fees may result in the refusal of future appointments and/or refills until paid.

I have read and understand in full the above statements.

_____ _____

Patient/Guardian Signature **Date**

NeuroPsych Center Of Greater Cincinnati

Telehealth Informed Consent Form

I, _____, consent to engaging in telehealth with NeuroPsych Center of Greater Cincinnati as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, medication management and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,

3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of NeuroPsych Center of Greater Cincinnati that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

   In addition, I understand that telehealth based services and care may not be as complete and in-person services. I understand that if my provider believes I would be better served by other interventions I will be referred to other mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my provider, my condition may not improve, or may have the potential to get worse.

4. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Skype, Facetime, GoToMeeting, Zoom, and Google audio/video systems are not 100% secure and may have issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold NeuroPsych Center of Greater Cincinnati or its staff liable for gathering or use of client information by these service providers.

5. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my provider, and all of my questions regarding the above matters have been answered to my approval.

6. By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychiatry/psychological services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

NeuroPsych Center Of Greater Cincinnati

Patient Consent to the use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize NeuroPsych Center of Greater Cincinnati to use telemedicine in the course of my diagnosis and treatment.

_____	_____	_____
Patient/Guardian Signature	Date	Relationship to patient

I have been offered a copy of this consent form (patient's initials) _____

NeuroPsych Center Of
Greater Cincinnati

Dear Neuro Psych Center of Greater Cincinnati Patient:

We work hard to make sure that your financial obligation to NCGC remains manageable. To this end we make every effort to keep your account current. Providing us with your credit card authorization helps in this effort.

When possible, and your consent, we will file claims with your insurance carrier. As an insured member of your insurance carrier, you have a contractual obligation to pay your deductible and co-pay in order to access your insurance carrier's network. NCGC has the obligation to collect this deductible and co-pay. By both of us completing our parts, you are allowed access to preferential discounted provider fees that have been contracted with your insurance company. Further, if there are charges that your carrier does not cover it is important that we collect in a timely manner.

We believe that we have a moral obligation to you to assist you in any way we can for you to get access to these fees/rates and lower the cost to you, but we need your help.

When you complete a credit card authorization slip, you have provided the easiest and most assured way to allow to preferential rates.

If you choose to not provide this authorization, you will need to make sure you make these payments when you check in each time to receive discounted rates versus being subject to higher charges.

Please consider completing the authorization form attached.

Sincerely,

NeuroPsych Center of Greater Cincinnati

NeuroPsych Center Of
Greater Cincinnati

NeuroPsych Center of Greater Cincinnati

Consent for Electronic Billing Statement

I authorize my provider/ representative to send my bill to me via email for services rendered. I recognize that data transmitted over the internet may not be secure and is at risk to being read by unauthorized third parties. I understand that neither my provider nor their designated representatives will be held responsible for unauthorized access to my protected information while in transmission to me via email. I understand that neither my provider nor their representatives are responsible for safeguarding such information once it is delivered to me. I may revoke this authorization at any time in writing to my provider.

Patient/Guardian email address: _____

_____

Print Name Patient/Guardian Signature Date

_____

☐ I do not authorize statements to be sent via email at this time.

_____

Print Name Patient/Guardian Signature Date

NeuroPsych Center Of Greater Cincinnati

Today's Date: _____ Patient Name: _____

End date of authorization: One year from today's date

<u>Amount not to exceed $250 per transaction</u>

Card holder Information:

Cardholder Name: _____

Cardholder Address: _____

_____

Billing Zip code: _____

Type of card: □ Visa □ Mastercard □ Discover □ American Express

Card number: _____

Expiration date: _____

CVV (three-digit number on back of card) _____

Is this a Health Savings Card from your insurance company? □ Yes □No

I hereby authorize NCGC to keep my debit or credit card or bank account information (as indicated above) on file for payment and to initiate appropriate payment entries against the above referenced debit or credit card or bank account, as applicable, as amounts are owed by me on the Patient Account listed above. I acknowledge that the initiation of all such entries to make payments on the Patient Account listed above must comply with the provisions of U.S. law and any applicable state laws. I understand and agree that these entries may be made to my debit or credit card or bank account, as applicable, periodically to pay amounts owed by me on the Patient Account listed above. I also agree to notify NCGC if my debit or credit card or bank account information (as indicated above) changes for any reason. This authorization shall remain in effect until the "End Date of Authorization" listed above or until I communicate to NCGC my intention to cancel this authorization by calling NCGC at 513-563-0488 or writing to NCGC at the address above. I acknowledge receipt of a copy of this authorization form.

Signature:_____ Date:_____

NeuroPsych Center Of
Greater Cincinnati

Insurance Reimbursement

We all know how confusing insurance, and the benefits provided, can be. At NeuroPsych Center of Greater Cincinnati our goal is to help you use your insurance benefits for care. While we do check on your insurance benefits, we can't guarantee that this initial benefits check will be what the insurance actually accepts. Because you are the person covered you have to take the responsibility for knowing what your benefits are and for communicating any inconsistencies directly with your insurance company.

Co-pays for services are due at the time of service. If you have a deductible that has not been met then full payment for the service would be due at the time of service.

We often receive denials for payment from insurance companies that we are unable to resolve with them. When problems arise with obtaining reimbursement from insurance companies for services provided and we are unable to resolve the issue, it is the client's responsibility to resolve the problem or pay the outstanding charge.

You are responsible for payment if the insurance company denies your claim. Listed below are a few of the major reasons for denial.

1. If an insurance company authorizes additional sessions that exceed the clients benefit plan. It is each client's responsibility to know how many sessions are provided by his or her policy and to know when the benefits have been used. Although we verify benefits with your insurance company, we are sometimes given misinformation.
2. If the client receives therapy at NCGC and medication from a psychiatrist outside the practice, it is likely that both practitioners are jointly limited to the annual number of sessions allowed.
3. Clients are responsible for knowing if they require pre-authorization of services.
4. If you change insurance plans, secure pre-authorization and supply NCGC with all new insurance information prior to being seen under your new insurance. Services may be denied if pre-authorization is not obtained.
5. If a denial for services is due to ineligibility at the time of service, the client will be charged the full session fee and be responsible for payment.

We appreciate that you have chosen NCGC to provide services.