NAME: _____ **DOB**_____

NEUROPSYCH CENTER OF GREATER CINCINNATI

Consent to Treat

I hereby certify that the Neuropsych Center of Greater Cincinnati (NCGC) 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 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 NCGC 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 Neuropsych Center of Greater Cincinnati to contact my primary care physician:

_____, M.D.

_____
(Phone Number

_____
(Street Address)

_____
(City, State, 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

PATIENT REGISTRATION

Patient Information

Date: _____

Name_____

Address _____

City _____ State _____ Zip _____

Primary # to leave a message _____

Home # _____ Cell # _____ Work #_____

Birthdate _____ M or F Social Security # _____

Are you: □ Single □ Married □ Divorced □ Separated □ 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 # _____

Policy Holder 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 (fill out information below)

Are we able to contact this person regarding payment and billing information? □ YES □ NO

Name _____ DOB _____

Relationship_____

Address _____

City _____ State _____ Zip Code _____

Home # _____Cell # _____ Work # _____

SS # _____

Emergency Contact

Name _____ Relationship _____

Primary contact# _____ Secondary contact# _____

NEUROPSYCH CENTER OF GREATER CINCINNATI

Name: _____ Maiden: _____
(Last) (First) (M.I.)

Date Of Birth: _____ Age: _____ Race: _____

CURRENT LIVING SITUATION

Current Residence (Home, Apartment, Asst. Living Etc.): _____

_____

Describe Residence: _____

_____

_____

Who Lives with You? _____

Who Helps You? (list names and what they do for you, i.e. shopping, bathing, meal preparation etc.)_____

_____

_____

_____

How Often Do You See Family/Friends? _____

_____

_____

Who Do You Call in An Emergency? _____

_____

What Is Your Main Source of Transportation? _____

_____

Who Manages Your Money? _____

_____

Are Finances a Major Concern, If Yes, why? _____

_____

How Often Do You See Your Doctor or Access Medical Care? _____

_____

When Have You Last Seen a doctor or Access Medical Care? _____

_____

Who Did You See and For What Reason Did You See Them? _____

NEUROPSYCH CENTER OF GREATER CINCINNATI

EARLY LIFE HISTORY

Place of Birth:_____

Father's Name:_____ Occupation:_____

If Deceased, Cause of Death:_____

Relationship with Father:_____

Mother's Name:_____ Occupation:_____

If Deceased, Cause of Death:_____

Relationship with Mother:_____

Siblings:	Name	Age
	_____	_____
	_____	_____
	_____	_____
	_____	_____

General Relationships with siblings:_____

_____

Describe Early Development History:_____

_____

EDUCATIONAL BACKGROUND

Highest Level of Education Achieved:_____

Grades (circle one): Above Average Average Below Average

If Dropped Out, Why?_____

Vocational Skills/Training:_____

NEUROPSYCH CENTER OF GREATER CINCINNATI

EMPLOYMENT BACKGROUND

Prior Employers and
Positions: _____

_____

_____

_____

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

MILITARY HISTORY

Dates of Service: _____ Highest Rank Achieved: _____

Type of Discharge: _____

Any Significant Influence on Current

Functioning: _____

_____

MARITAL HISTORY

How many times married: _____

Current Marital Status (circle one): Married Divorced Separated Never Married Widowed

Spouse's Name: _____ Age: _____

Number of Years Married: _____

Describe the general quality of the

relationship: _____

_____

_____

NEUROPSYCH CENTER OF GREATER CINCINNATI

Children: Name/Location Age

_____ _____

_____ _____

_____ _____

_____ _____

Describe the Quality of the Relationship: _____

_____

_____

Number of Grandchildren: _____ Number of Great Grandchildren:_____

RELIGIOUS BACKGROUND

Religious Affiliation: _____

Importance of Religion: _____

LEISURE ACTIVITIES/COMMUNITY INVOLVEMENT:

Hobbies/Leisure Activities: _____

HEALTH HISTORY

Current Medical Problems

Describe Symptoms: _____

_____

How Long Have Symptoms Existed: _____

Current Medications Dose

_____ _____

_____ _____

_____ _____

NEUROPSYCH CENTER OF GREATER CINCINNATI

LEGAL HISTORY

Describe:_____
_____
_____

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

NCGC Authorization to release reports from Geriatric Assessment
Upon completion of the geriatric assessment, NCGC will release information only to parties designated by the patient.

Please indicate below which parties NCGC should forward this information to:

I would prefer this information be emailed to: _____.

or mailed to

Patient or Family Member:

Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Information to be released:

- Completed assessment report
- Verbal report of findings
- Other_____

Physician:

1. Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Information to be released:

- Completed assessment report
- Verbal report of findings
- Other_____

I authorize NCGC to release the information I have designated to the above two parties.

Signature of Patient: _____ Date: _____

Name of Patient: _____

☐ FAXED:_____
☐ MAILED:_____

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: 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

OHIO NOTICE FORM
NEUROPSYCH CENTER OF GREATER CINCINNATI
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. <u>IV. Patient's Rights and NCGC's Duties</u>

<u>Patient's Rights:</u>

- *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 the entire 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'S 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 ***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.