Neponset Valley Neuropsychology, LLC.

Consent to Services

Name:_____ DOB:_____ Age: _____

Gender: (please circle) Male Female Other:_____ Race: _____

Address:_____

City:_____ State:_____ Zip code: _____

Cell Phone:_____ Home Phone: _____

Email:_____ Primary Care Provider: _____

Text Message Appointment Reminder Consent: (please circle) No Yes Phone: _____

Responsible Party: (*signature required below*)

The Responsible Party is who is responsible for payment of all costs incurred. It is, however, understood and agreed that the Responsible Party is responsible for all costs for services rendered by Neponset Valley Neuropsychology if insurance does not pay for these services.

Name:_____ DOB:_____

Address:_____

Relationship to Patient:_____ Primary Phone: _____

Confidentiality Statement:

As a patient, all information you share about yourself will be kept confidential. Only with your written permission will information be released to anyone outside of Neponset Valley Neuropsychology except as required by law. Legal exceptions include clear and imminent danger to you or someone else, if there is a reasonable expectation that you will engage in dangerous conduct as defined by Massachusetts state statute, reasonable suspicion that a child or elder is currently being abused, or a court order.

Cancellation Policy:

We require an active credit or debit card on file as a means of appointment security. This card will be charged for any outstanding balances and/or late cancellation/no-show fees. This information will be destroyed at the end of your evaluation. By signing this form, you agree to commit to your appointment or cancel with more than 24 hours' notice or otherwise be subject to a late cancellation fee. It is your responsibility to call to reschedule your appointment(s). Fees for missed appointments are not covered by your insurance company. We reserve the right to charge you a total of $175.00 for canceling 1-hour appointments without a 24 hours' notice or not showing. We reserve the right to charge you a total of $500.00 for canceling 3-hour testing appointments without a 24 hours' notice or not showing. The late cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Patients who cancel and reschedule to excess are subject to discharge from the practice.

I hereby consent to the provision of care, diagnosis and/or treatment by Neponset Valley Neuropsychology. I hereby understand that no guarantee can be made to me as to the results, diagnostic impressions, and treatment recommendations. I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I understand that at any time, I can request information on my patient rights and summary of privacy practices.

I understand that supplying my provider with supplemental paperwork will be subject to a completion fee at the discretion of the provider based on estimated time to complete. I understand the minimum completion fee rate is $75 per 1-30 minutes of paperwork (*additional rates may apply depending on estimated time to complete*).

I hereby understand that it is my responsibility to verify coverage and deductibles with my insurance company prior to consenting to services. If I am delinquent in updating this information and the charges are denied, I understand that I will be held responsible for these charges. I agree to be financially responsible for all visits not covered. Although Neponset Valley Neuropsychology will attempt to get prior authorization to the best of their ability, it is my responsibility to verify that authorization was obtained. It is my responsibility that any co-payments and/ or outstanding balances are my contractual responsibility and payable to Neponset Valley Neuropsychology at the time of my visit for copays and immediately after my visit for an outstanding balance. I hereby understand that any outstanding balances may be automatically charged to my credit card on file for the full balance amount if there is no agreed-upon financial arrangement within 30 days of receiving my invoice. If payment arrangements are not kept, the account will be sent to collections. If balance is not paid within 30 days of receiving an invoice, the account will be sent to collections. It is my responsibility to inform Neponset Valley Neuropsychology of any changes to my insurance during my evaluation process. If I do not notify Neponset Valley Neuropsychology of any changes to my insurance in a timely manner, I understand I am liable for any charges for services not covered by my insurance.

Signature:_____ Date:_____ (signature of Patient)

Signature:_____ Date:_____ (signature of Responsible Party)

Neponset Valley Neuropsychology
45 Walpole Street – Suite 6
Norwood, MA 02062

TEL: 781-769-1646 **FAX: 781-769-4696**

Appointment Security Deposit

Dear Patients,

As a reminder, when you scheduled your Initial Consult, you paid a $100 security deposit. This deposit is **refunded** at the completion of your evaluation OR applied to a No-Show fee or Late Cancellation fee (outlined in the Consent to Services form).

The deposit is **refunded** under the following conditions:

- Calling to cancel your Initial Consult more than 24-hours prior to the scheduled time
- Calling to cancel the remainder of your evaluation more than 24-hours prior to the next appointment (i.e., Testing or Feedback)

When the deposit is **refunded**, it may take 7-14 business days to process

Please call our office for any questions or concerns

Neponset Valley Neuropsychology
45 Walpole Street – Suite 6
Norwood, MA 02062

Credit/Debit Card Authorization:

Neponset Valley Neuropsychology, LLC **requires** a credit or debit card on file for all services to ensure dedication to treatment. We will NOT charge this card without your permission, EXCEPT in the following cases:

Your card will be charged automatically for the full outstanding amount including deductibles. Please check the boxes below to indicate understanding of these circumstances:

☐ Late cancels or appointment no-shows as detailed in the Consent to Services

☐ Your bill is more than **30 days** past due without a payment plan in place, this applies to ALL services

I, _____, authorize Neponset Valley Neuropsychology, LLC to use my credit/debit card information to charge my credit/debit card. I understand that this card will be charged for either late cancellations, no-shows, and past due balances, as outlined in the Consent to Services.

PLEASE PRINT CLEARLY - ALL FIELDS REQUIRED

Card Type (circle one): Visa Mastercard Discover American Express Other

Card #: _____ - _____ - _____ - _____

Expiration Date: _____ Security Code on back of card: _____

Name as printed on card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Email: _____

By signing below, I am authorizing Neponset Valley Neuropsychology, LLC to charge the above card in the designated manner. My signature also indicates that I will inform my clinician of any changes to this billing information over the course of my evaluation.

_____

Patient or Guardian Signature *Patient or Guardian Printed Name* *Date*

Neponset Valley Neuropsychology, LLC.
45 Walpole Street – Suite 6
Norwood, MA 02062
Tel: (781) 769-1646 **Fax: (781) 769-4696**

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

I hereby authorize Neponset Valley Neuropsychology, LLC. to (**check all that apply**):

_____ TO **RELEASE** COPIES OF MY MEDICAL RECORDS FROM:

(For receiving providers: Please send most recent office notes and any neuroimaging reports to our office for review.)

_____ TO **RELEASE** COPIES OF MY NEUROPSYCHOLOGICAL REPORT TO:

Primary Care Provider (PCP): _____ Phone: _____

Additional Provider: _____ Phone: _____

Additional Provider: _____ Phone: _____

Other: _____ Phone: _____

I hereby authorize Neponset Valley Neuropsychology, LLC. to discuss all details related to my evaluation and care with:

Family: _____ Phone: _____

Other: _____ Phone: _____

I understand that once Neponset Valley Neuropsychology, LLC, discloses my health information to the recipient, Neponset Valley Neuropsychology, LLC, cannot guarantee that the recipient will not disclose my health information to another party. I have read and understand the terms of this authorization. By my signature below, I hereby knowingly and voluntarily authorize Neponset Valley Neuropsychology, LLC, to use or disclose my health information in the manner described above.

_____
Signature of patient

Date: _____
Authorized signature valid for 2-years from printed date

_____
Signature of patient's legal guardian/representative

Date: _____
Authorized signature valid for 2-years from printed date

Neponset Valley Neuropsychology, LLC.

Patient History

Date: _____

Name: _____ DOB: _____ Age: _____

Race/Ethnicity: _____ Handedness: _____

Referring Provider: _____ Primary Care Provider: _____

What are your symptoms? Please be as specific as you can. How long have you had these symptoms?

_____

_____

_____

What medications are you currently taking? (attach a list if you have one)

Medication	Dose	Prescribed For?	Start Date	Side Effects

Any CT or MRI scans of the brain? If yes, where and when? _____

General Medical History:

Do you have any of the following conditions? If yes, please check.

Sleep Apnea	☐	Heart Attack	☐	Chronic Pain	☐
Elevated Blood Pressure	☐	Diabetes	☐	Depression	☐
Elevated Cholesterol	☐	Difficulty Walking/Balancing	☐	Anxiety	☐

Other general medical conditions: _____

Neurological History: Please check and describe:

Stroke/TIA	☐	Seizure(s)	☐	Head Injury	☐
Headaches/Migraines	☐	Hearing Problems	☐	Vision Problems	☐

If any checked or not listed, please describe: _____

_____

Family History: Is there a family history of any of the following? If yes, check and state whom.

Dementia	☐ _____	Stroke	☐ _____	Substance Abuse	☐ _____
Depression	☐ _____	Anxiety	☐ _____	Bipolar Disorder	☐ _____
Learning Disability	☐ _____	ADHD	☐ _____	Cardiovascular Disease	☐ _____

Daily Functioning: Check and/or describe all that apply.

Tobacco (frequency & amount): _____ Marijuana (frequency & amount): _____

Alcohol (frequency & amount): _____ Caffeine (frequency & amount): _____

Appetite Change: _____ Weight Change: _____

Exercise (frequency & amount): _____ Sleep Problems: _____

Have you had any recent stressors or stressful life events in the past year? If yes, please describe.

_____

Past or current psychotherapy? If so, for how long? Helpful? _____

Social History:

Marital Status: _____ Children: _____ # of Siblings: _____

Currently live with? _____ Where were you raised? _____

Highest Education: _____ Academic Performance: _____

Are you currently employed/in school? _____

Retired? What was your profession and for how long? _____

On disability? If yes, for what condition and for how long? _____

What specific questions do you hope this evaluation will answer: _____

_____

_____

Additional relevant information: _____

_____

_____

_____

_____