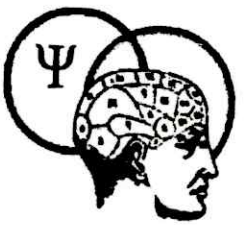
NEUROPSYCHOLOGIC ASSOCIATES, PLLC



Patient Information Sheet

Please fill out this form completely, write N/A where applicable and sign. Thank you.

Referral Source: _____

Patient's Name: Last_____ First_____ M.I._____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____ Work: (___) _____

Cell Phone: (____)_____ E-mail: _____

Patient's Sex: Male_____ Female_____ Patient's Date of Birth: _____

Is Patient Married? _____ Name of Spouse: _____

Emergency Contact: _____ Phone Number: (____) _____

Patient's Insurance Information

Primary Insurance Company Information:

Company Name: _____

Address: _____

Insurance #: _____

Group #: _____

Secondary Insurance Company Information:

Company Name: _____

Address: _____

Insurance #: _____

Group #: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

I hereby authorize the release of any medical information necessary to process this claim and hereby assign Neuropsychologic Associates, PLLC. all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Patient's Signature: _____ **Date:** _____

98 PARK AVENUE • BABYLON, NY 11702

PHONE: (631) 482-1200 • WWW.NEUROPSYCHLI.COM • FAX: (631) 482-1203

NEUROPSYCHOLOGIC ASSOCIATES, PLLC

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

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NEUROPSYCHOLOGIC ASSOCIATES, PLLC

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Neuropsychologic Associates, PLLC is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

- I acknowledge that I have received a copy of [Private Practice / Private Practitioner Name's] HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
- I understand that [Private Practice / Private Practitioner Name] reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

Patients Name _____ Date_____

Signature of Client or Legal Representative _____

Relationship to Client _____

Please Note: It is your right to refuse to sign this Acknowledgement. HIPAA Privacy Notice Acknowledgement

_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of our Notice of Privacy Practices Acknowledgement, but was unable to do so for the following reason

_____

Initials: _____ Date: _____

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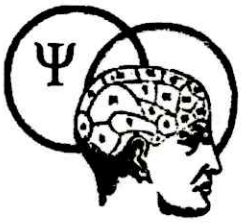

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and individuals also described below:

Description of the specific information to be used or disclosed:

All personal and medical information

Person or entity requesting the information and authorized to make the requested use or disclosure:

All hospitals, physicians, labs, and any others with whom my care is coordinated

Recipient of the information: _____

This information is being requested for the following purpose(s): treatment, coordination of care and payment.

This authorization shall remain in effect from the date signed below until five (5) years from the date of patient's signature.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed;
- I may revoke this authorization in writing by contacting your office at the address listed below, attention Privacy Officer;
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA;
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide the research-related treatment).

  If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information

Patient Name: _____ Signature: _____

Relationship to patient (if signed by personal or legal representative of patient) :

_____

Date: _____

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NEUROPSYCHOLOGIC ASSOCIATES, PLLC

Patient Policy and Patient Responsibility

Thank you for choosing Neuropsychologic Associates, PLLC. as your mental health provider. We are committed to providing quality and affordable care. Please read the following policies and sign where indicated. A copy will be provided to you upon request.

1. **INSURANCE** – Your insurance billing information and benefits are your responsibility. Please contact your insurance company with any questions you may have regarding covered services.
2. **CO-PAYMENTS** – Co-pays are the patient's responsibility and must be paid at the time of service. This arrangement is part of the contract between you and your insurance company.
3. **DEDUCTIBLES & CO-INSURANCE** – All deductibles and co-insurance amounts are the patient's responsibility and will be billed to you after the insurance has processed the claim. This arrangement is part of the contract between you and your insurance company.
4. **NON-COVERED SERVICES** – Please be aware that some or all the services provided to you during your visit may not be covered by your insurance company. Any non-covered charges are the patient's responsibility. Please call your insurance carrier to appeal any non-covered charges.
5. **PROOF OF INSURANCE** – All patients must complete the patient registration form before receiving any services through our facility. We also require a copy of a valid photo ID, such as State driver's license, and a copy of your current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.
6. **CLAIMS SUBMISSION** – Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit claims both to primary and secondary insurance. Some insurance companies require patients to submit information directly, and, if so, this is your responsibility. Please be aware that if your insurance company does not pay the balance of the claim, it is your responsibility.
7. **COVERAGE CHANGES** – It is important to notify us as soon as possible of any changes pertaining to your insurance coverage. Failure to do so may result in unpaid claims, for which you are responsible.
8. **UNINSURED/SELF-PAY PATIENTS** – If you are seeking services at our facility and do not have insurance, payment is required prior to your appointment. $150.00 for new patient diagnostic interview appointments and $100.00 for established patient appointments.
9. **STATEMENTS** – Patient statements are mailed monthly and payment is required upon receipt of your statement. If your account is over 30 days past due and arrangements for payment have not been made, you will receive a letter stating that you have 30 days to pay your account in full. If a balance remains unpaid, we will refer your account to a collection agency.
10. **RETURNED CHECKS** – If you pay with a check and your check is returned, your account will be charged a $36.00 fee which you will be responsible for along with the amount of the payment.

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11. **MISSED, CANCELLED, and/or RESCHEDULED APPOINTMENTS** – We require a 24-hour notice on all appointment cancellations and reschedules. Our policy is to charge a $25.00 fee billed directly to the patient or responsible guardian per missed appointments.
12. **HARASSMENT** – This is a private practice where we strive to create a pleasant environment for all patients and staff. We understand that there are times when patients may be frustrated and we will make every attempt to assist you. However, this Practice will not tolerate physical abuse, verbal abuse, or harassment of any kind under any circumstance. Abuse or harassment in any form is grounds for patient discharge.

"I acknowledge that I have read, understand and will follow all policies and responsibilities herein stated. I acknowledge that I am responsible for all charges for services rendered. If it becomes necessary to commence collection for any amount owed on this or subsequent visits, the undersigned agrees to pay for any and all legal costs and expenses incurred. I also hereby authorize NEUROPHYCHOLOGIC ASSOCIATES, PPLC. to release information necessary to secure payment.

_____

Patient's Name (Print)

_____ _____

Patient or Legally Authorized Representative's Signature Date

_____ _____

Legally Authorized Representative's Signature (Print) Relationship to Patient