Neuropsych Associates

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Neuropsych Associates for the purpose of diagnosing or providing treatment to me and in obtaining payment for healthcare bills. I understand that diagnosis or treatment of me by the practitioners may be conditioned upon my consent as evidence by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Neuropsych Associates is not required to agree to the restrictions that I request. However, if Neuropsych Associates agrees to a restriction that I request, the restriction is binding on Neuropsych Associates. I have the right to revoke this consent, in writing, at any time, except to the extent that Neuropsych Associates has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by Neuropsych Associates, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Neuropsych Associates’ Notice of Privacy Practices prior to signing this document and this has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the professional healthcare operations of Neuropsych Associates. This notice also describes my rights and Neuropsych Associates’ duties with respect to my protected health information.

Neuropsych Associates reserves the right to change the Privacy Practices that are described. I may obtain a revised copy by requesting such copy.

I have read the above and understand that I have the right to revoke this consent, in writing, at any time.

_____ _____

Patient Signature Date

_____

Printed Name

No Show and Cancellation Policy

An appointment with a Neuropsych Associates provider reserves a period of time just for you. A cancelled appointment or a no show keeps others from having access to that provider.

- We require at least 24 hours notice of cancellation in advance of your scheduled appointment.
- All no shows for appointments will be charged $65.00 and late cancellations will be charged $35.00 for the missed appointment. This fee must be paid prior to receiving future services.
- Chronic cancellations can be cause for full charge of session of $100.00 in advance of future appointments. Medical insurance cannot be billed for missed appointments.

I (we) have read, understand and agree with the provisions of this Cancellation Policy.

Person responsible for the account: _____ Date: _____

Co-responsible party: _____ Date: _____

Authorization For Disclosure Of Healthcare Information

Patient Name: _____ Birth Date: ____/____/____

I authorize Neuropsych Associates to release/exchange the following information (please initial all applicable options):

_____ Psychological/Psychiatric Records
_____ Evaluation and Treatment
_____ Information related to Chemical Dependency/Substance Abuse
_____ Information related to HIV/AIDS and/or Sexually Transmitted Diseases
_____ Psychological/Neuropsychological Assessment
_____ Other:_____

to/with the following people (please include your doctors and other healthcare professionals with whom we can share information:

Name	Address	City	State	Zip	Phone
Name	Address	City	State	Zip	Phone
Name	Address	City	State	Zip	Phone
Name	Address	City	State	Zip	Phone
Name	Address	City	State	Zip	Phone

Parent/Guardian signature is required for all children under age 18. For children age 18 and over, we encourage the parent/guardian to sign, but it is not required. I understand that information being requested for the above minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

_____ _____
Signature of Parent/Guardian Date

I understand that I may revoke this Authorization at any time except to the extent that action has been taken.

Consent for Communication and/or Disclosure

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Neuropsych Associates.

We have permission to:

Call you at home? ☐ yes ☐ no
If yes, can we leave the following information on your home answering machine or voicemail?

Appointment information ☐ yes ☐ no
Billing information ☐ yes ☐ no
Medical information ☐ yes ☐ no

Can we call you at work? ☐ yes ☐ no
If yes, can we leave the following information on your work answering machine or voicemail?

Appointment information ☐ yes ☐ no
Billing information ☐ yes ☐ no
Medical information ☐ yes ☐ no

I give my permission to share the following information with the person(s) named below:

Name: _____ Relationship: _____
Appointment ☐ yes ☐ no Billing ☐ yes ☐ no Medical ☐ yes ☐ no

Name: _____ Relationship: _____
Appointment ☐ yes ☐ no Billing ☐ yes ☐ no Medical ☐ yes ☐ no

Name: _____ Relationship: _____
Appointment ☐ yes ☐ no Billing ☐ yes ☐ no Medical ☐ yes ☐ no

_____ _____
Patient Signature Date

_____ _____
Witness Date

Notice Of Policies And Practices To Protect The Privacy Of Your Health Information (HIPPA Notice Form)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures for Treatment, Payment and Healthcare Operations

We may use or disclose your protected health information (PHI) for treatment, payment and healthcare operations purposes with your consent. To help clarify these terms, here are some definitions:

- PHI refers to information in your health record that could identify you.
- Treatment is when we provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment would be when we consult with another healthcare provider, such as your family physician or another psychotherapist.
- 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 healthcare or to determine eligibility or coverage.
- Healthcare operations are activities that relate to the performance and operation of our practice. Examples of healthcare 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 office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment and healthcare 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 healthcare operations we will obtain an authorization from you before releasing this information. We will also need to obtain an 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 are 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.

Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Knowledge of child abuse, abuse of vulnerable adults, or abuse of members of any legally protected class. HIPPA allows such disclosures. Florida Law requires reporting in certain cases.
- Health oversight:
  If we receive a request from the Florida Department of Health with respect to an inquiry or complaint about our professional conduct, we must make available any record relevant to such inquiry.
- Judicial or administrative proceedings:
  If you are involved in a court proceeding and a request is made for information about your 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 legally appointed representative, or 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:
  We may disclose confidential information from your record if we believe such disclosure is necessary to protect you or another person from a clear and substantial risk of imminent, serious harm. We may only disclose such information and to such persons as are consistent with the standards of our profession in addressing such problems.
- Worker's compensation:
  If you file a worker's compensation claim, and if we provide treatment to you relevant to that claim, then we must submit to your employer's insurer or a third party administrator a report on services rendered.

Patient's Rights and Duties of Health Care Professionals

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.
- 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 me. Upon your request, we will send bills to another address.
- Right to inspect and copy:
  You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing record used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On you request, we will discuss with you the details of the request and denial process.

- 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 proved 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.
- 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.

Professional's Duties

- We are required by law to maintain the privacy of PHI and to provide you with a 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. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a copy of the revised notice, in person, or via mail.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your record, you may contact the State of Florida Department of Health. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date, Restrictions and Changes to Privacy Police

This notice will go into effect on January 1, 2012. 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 provide you with a revised notice by mail or in person.