# Brain and Behavioral Health

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## ** Registration Information **

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: ____ Zip Code: _____

**Phone Number**: (Home) _____ (Cell) _____

**Marital Status**: married – widowed – single – divorced **Spouse's Name**: _____

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**If spouse or parent is the subscriber/main cardholder for your insurance, we need his/her information**

Spouse or Parent Date of Birth: _____

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Your Primary Care Physician: _____

What Physician referred You?: _____

Reason You Are Here Today:

_____

_____

## ** Insurance Information and Authorization **

Primary Insurance: _____

Secondary Insurance: _____

We will ask to make a photocopy of your insurance cards. If this service is related to a Worker's Compensation or Automobile accident, you will be asked to provide the necessary contact information. If you provide authorization to us to bill your insurance policy, we will be required to provide information to the insurance company to verify the service provided. This information includes your name, the date of service, the type of service provided, and a diagnosis code to establish medical necessity. Your insurance company may request other information to authorize payment, including treatment notes. This is protected information, and in compliance with HIPAA regulations, we will provide only the information necessary to obtain reimbursement.

The service today will be billed by the hour. An hour of psychotherapy will last 45-50 minutes, with the balance of the time dedicated to documentation related to the session. In accordance with CMS standards of practice, billing for neuropsychological assessment will include time to gather referral information, administer tests, score tests, interpret tests/interview/records, prepare the report, and provide necessary feedback to the referring physician. In most cases, this will typically add 1-3 hours to the actual testing time. Therefore, the typical testing procedure will generate 4-6 hours of service that will be billed to you or your insurance policy. You are required to pay all co-pays and coinsurance amounts. Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for any balance not covered by your insurance policy. As a courtesy, we will bill your insurance for you. We will make every effort to ensure that claims are complete and accurate when submitted. However, follow up on your insurance claim is your responsibility. In certain circumstances, we will make arrangements for a payment plan.

**Medicare:** Our doctors are participating providers and, therefore, accept assignment for those covered by Medicare. We will also bill any secondary insurance policies, but you will be responsible for any balance remaining after all policies have been billed. Most secondary insurances cover the coinsurance, often resulting in no out of pocket expense to you, assuming you have met your annual deductibles. However, if your secondary insurance does not cover the coinsurance amount, this can result in a balance due to you. If this is the case, the typical amount is between $100-$150.

**Blue Cross/Blue Shield:** Our doctors are participating providers for most Blue Cross/Blue Shield policies, but you are responsible to determine if we are providers for your particular Blue Cross/Blue Shield policy. This can be accomplished by calling the customer service number on your card. This means that most often we will be able to bill BC/BS, work within their fee schedule, and receive reimbursement from Blue Cross/Blue Shield. When this is the case BC/BS typically pays 50%-90% of the normal and customary fee. This provides a benefit, but continues to leave a co-pay for services. Counseling is reimbursed at 50%, leaving a typical, substantial co-pay of approximately $50 for counseling. If either of our doctors are not providers for your Blue Cross/Blue Shield policy, the typical fee for neuropsychological testing is $700-$800.

**Priority Health:** Our doctors are providers for neuropsychological testing services with Priority Health. Priority Health typically covers the cost of testing.

**All other insurance carriers:** Each insurance company covers the costs of counseling or testing differently. Office staff will provide guidance and provide billing support, but you are responsible to determine the type of coverage you have.

***AUTHORIZATION***

I certify that the information as given on this form is correct and complete to the best of my knowledge.
I hereby authorize the release of any medical or other information to be shared with all health care providers involved in my care.
I hereby authorize the release of any medical or other information necessary to process this claim and/or any payments.
I assign, transfer, and set over to the Brain and Behavioral Health provider all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy(ies) for services rendered.

I further agree to pay for any and all services not paid by my insurance benefit plan(s).

In the event that my health insurance plan falls under the jurisdiction of ERISA law, I designate my Brain and Behavioral Health provider as my authorized representative to act on the claimant's behalf for all claims assigned to the provider of services.

Signed: _____ Date: _____

**We are pleased you have chosen to come to our clinic. Please do not hesitate to request clarification of any clinic policies or ask any other questions regarding your service. We are happy to respond to any concerns.**

# ** Consent for Psychological Treatment or Testing **

## Counseling

The purpose of counseling is to relieve stress, anxiety, and depression. However, like most medications, psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, and frustration. Psychotherapy has been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, better relationships, and resolutions of specific problems. Therapy involves a large commitment of time, money, and energy, so you should be careful about the therapist you select. If you have any questions about our procedures, please discuss them whenever they arise. If your doubts persist, our doctors will be happy to assist to secure an appropriate consultation with another mental health professional.

## Testing

This evaluation is requested to assist your physician or other health care provider in their diagnosis and treatment of you. The material from the interview and psychological/neuropsychological testing will result in the generation of a report that will provide information related to your diagnosis and treatment. The report generated by our doctors will be sent to your physician or other health care provider, and we may also discuss the results of the evaluation with your physician. If this evaluation is being covered or partially covered by insurance, we may be required to provide the insurance company with a report as well.

## Confidentiality

In general, the confidentiality of all communications between a client and a psychologist is protected by law, and we can only release information to others with your permission. However, there are a number of exceptions. For example, in most judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances such as determinations of decision-making capacity, judges may require the doctor's testimony if they determine that resolution of the issue before them demands it. Also, we are required to notify authorities in any circumstance where a child, elderly person, or disabled person is being abused, or if there is reason to believe that you may harm others or yourself.

These situations occur rarely in our practice. However, should any situation occur, our providers will make every effort to fully discuss the situation with you before any action is taken.

If you have any questions regarding confidentiality, we will be happy to discuss any concerns with you. Otherwise, please sign below to provide your informed consent for our doctors to provide treatment to you.

Sign: _____ Date: _____