INSIGHT
SURGICAL HOSPITAL

New Patient Information Form:

Today's Date: _____ Who referred you to our office? _____

First Name: _____ Middle: _____ Last: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Phone Number 1: _____ Phone Number 2: _____

Sex: Male ❑ Female ❑ Race/Ethnicity: _____ Handedness: Right ❑ Left ❑

Student: Yes ❑ No ❑ Years of Education: _____ Highest Degree Attained: _____

Marital Status: Married ❑ Single ❑ Other ❑ Name of Spouse/Partner: _____

Are You Currently Employed: Yes ❑ No ❑

Employer Name and Phone Number: _____

Briefly describe your current symptoms:

_____

_____

_____

How long have your symptoms been present? _____

Do your current symptoms negatively impact you in any of the following areas? (check all that apply)

Home ❑ Work ❑ School ❑ Socially ❑ Other: _____

Are you currently being seen by any other doctors? ❑ Yes ❑ No
If so, please provide:

Name: _____ Phone Number: _____

Address: _____ City/State: _____ Zip: _____

Profession: ❑ Neurologist ❑ Psychiatrist ❑ Psychologist ❑Other _____

Name: _____ Phone Number: _____

Address: _____ City/State: _____ Zip: _____

Profession: ❑ Neurologist ❑ Psychiatrist ❑ Psychologist ❑Other _____

Name: _____ Phone Number: _____

Address: _____ City/State: _____ Zip: _____

Profession: ❑ Neurologist ❑ Psychiatrist ❑ Psychologist ❑Other _____

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Financial Information of Responsible Party/Legal Guardian (if applicable):

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

Phone Number 1: _____ Phone Number 2: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ Age: _____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____ City/State: _____ Zip: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

Phone Number 1: _____ Phone Number 2: _____

Insurance Information: *Please bring insurance card(s) and a photo ID to the check-in desk.*

Insurance Co. #1: _____ Insured's Name: _____

Relationship to Patient/Client: _____ DOB: _____

Insurance ID: _____ Group Number: _____

Insurance Co. #2: _____ Insured's Name: _____

Relationship to Patient/Client: _____ DOB: _____

Insurance ID: _____ Group Number: _____

Insurance Authorization and Assignment:

I, the undersigned, certify that I (or my dependent) have insurance with the above identified insurance company/companies and assign directly to Insight Neurocognitive Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for any amount not covered or reimbursed by insurance. I hereby authorize Timothy Franke, PsyD and Insight Neurocognitive Health and its associated departments to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Parent/Legal Guardian's Signature (*if applicable*) Date

_____ _____

Insured's Signature Date

A photocopy of this authorization and assignment shall be considered as valid as the original.

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Payment Policy

Cancellation/No Show Policy

A minimum of 48 hours of notice is required for cancellation of therapy appointments. If this notice is not received, you may be charged a penalty of $25. Please note, insurance cannot be billed for missed or cancelled appointments.

Copay:

Your copay is expected at the time of service and can be made at the 3rd-floor patient check-in office.

Insurance Filing and Coverage:

We will file our initial insurance claim(s) and provide documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. You may incur extra charges for refilling of insurance claims. If a service is not, or is only partially covered according to our understanding of your insurance policy, the service may be provided to you as long as you understand that there is no or limited coverage, and that you will be responsible for the costs of the service.

Payment:

In the event that your insurance does not cover our services (or any portion thereof) we will work with you regarding payment (e.g., setting up a payment plan). You bear ultimate financial responsibility for all services rendered to/for you, including workers' compensation claims and personal injury cases, regardless of the outcome of litigation. In the event that coverage is denied under workers' compensation, you will pay the unpaid balance, notwithstanding any appeal of such denial. With respect to personal injury cases, you are responsible for fees incurred. We do not accept contingency fee arrangements.

Guarantee of Payment and Assignment of Insurance Benefits:

For value received, the undersigned guarantor and/or patient (hereinafter referred to as "the Undersigned") promises to pay to Insight Neurocognitive Health (hereinafter referred to as "Provider") all charges incurred for services rendered to the Undersigned. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) but only as a courtesy to the Undersigned, and the Undersigned authorizes Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by Provider in the event insurance does not pay for these services. It is further agreed upon by the Undersigned that if, in the event that any monies received by Provider from the insurance carrier are at any time after their receipt withdrawn from Provider by the insurance carrier, the Undersigned will be responsible for those monies that due and owing, and waives any defense for payment that Undersigned may have against Provider. In the event that this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs, but including reasonable attorney's fees. The Undersigned authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized.

Liability:

We will do everything possible to ensure your safety during your time in our offices. However, please note that once you are outside the confines of our office suite, we are no longer able to do so. If you have any questions, please speak with our receptionist or with Dr. Franke directly. Your signature below indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

_____ _____

Patient / Legal Guardian Signature Date

_____ _____

Witness Signature Date

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Notice of Privacy Practices

Uses and Disclosures

Assessment and Treatment:

Your health information may be used by staff members or disclosed to other care professionals for the purpose of evaluation, diagnosis of health conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your health record to all health professionals who may provide treatment or who may be consulted by staff members.

Consultation and Case Presentations:

Your *de-identified* health information including but not limited to testing results and social history may be used or communicated to relevant professionals and relevant Insight staff for the purposes of case consultation and presentation. In all cases, your anonymity will be maintained.

Law Enforcement:

Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, for the protection of yourself and others, and to comply with mandated government reporting, as required by law. In addition, Insight Neurocognitive Health is compelled to respond appropriately to any and all court subpoenas.

Other Uses and Disclosures Requiring your Authorization:

Disclosure of your health information or its use for any purpose other than those listed above requires your specific, written authorization. You may submit a written revocation of the authorization at any time. However, your decision to revoke the authorization will not affect or reverse any use or disclosure of information that may have occurred before you notified us of your decision.

Additional Uses of Information:

Your health information may be used by our staff to remind you of your appointment.

Information about Treatments:

Your health information may be used in order to send you information concerning the treatment and management of your condition. We may also send you information regarding other treatments, options, or related services recommended following your evaluation.

Note:

Insight Neurocognitive Health and its providers are required by law to protect the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required by law to abide by the privacy policies and practices that are outlined in this notice.

Individual Rights:

- You have certain rights under federal privacy standards. These individual rights include the following:
- The right to request restriction on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Right to Revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information:

As permitted by federal regulation, we require that any request to inspect the copy protected health information must be submitted to us in writing. You may obtain a form to request access your records by contacting us directly.

Request for Restrictions on Protected Health Information:

You have the right to request us to restrict how we use and disclose your protected health information. However, we are not required by law to agree with your requested restrictions in certain situations. These situations may include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and/or any uses and disclosures described previously in this notice. However, if we decide to grant your request then we are bound by your agreement.

By signing below, I am hereby certifying that I have read, agreed to the Privacy Practices for Insight Neurocognitive health

_____ _____

Patient Signature Date

INSIGHT
SURGICAL HOSPITAL

Authorization for Release of Protected Health Information

My health record is private and is known under the law as "Protected Health Information (PHI)." By completing and signing this form, I, or my legal representative, agree to allow Insight Neurocognitive Health to share my PHI with the people or companies listed below. By Insight Neurocognitive Health, I also mean the organization's subsidiaries, affiliates, employees, agents, and subcontractors.

Regarding HIPAA, the new American Psychological Association (201) Ethical Principles of Psychologists and Code of Conduct states in Section 9.04 that testing data can be released to myself or to a person of my choosing if I sign a release of my information. In the absence of my release, my testing data can, and will, only be disclosed as required by law or court order.

I authorize Insight Neurocognitive Health and the administrative and clinical staff to release the following:

❑ Therapy notes and information related to

This information should only be released to the following person(s)/agencies:

1. _____
2. _____
3. _____
4. _____

This authorization shall remain in effect for 12 months (1 year) or until such time that it is revoked.

Start: _____ End: _____

As a patient, I have the right to revoke this authorization, in writing, at any time by sending such written notification the office address below. However, I cannot revoke any copies of my report that have already been sent out based on my earlier permission to do so. In addition, I cannot revoke my permission to send a copy of the report to my insurance company, if that was a condition of obtaining insurance coverage, and thus the insurer has the legal right to contest the claim.

Send written notification of revocation of authorization for release of protected information to:

Insight Neurocognitive Health
Suite 1900
4800 S Saginaw St.
Flint, MI 48507

I understand that once I authorize the release of my records to another person and/or agency, that there is no guarantee that my records will remain in confidence, and that it is possible that my records may be sent to other individuals. In theory, that individual may disclose protected health information for the proper management and