

**NOTICE OF PRIVACY PRACTICES**  
**EFFECTIVE DATE 09/18/2006**

This summary of our Notice of Privacy practices informs you of how we may use or disclose your health information. It also explains your rights and our duties under the current privacy laws.

OUR RIGHTS: We may use and disclose your health information to:

- Provide patient care and treatment and for the operation of our healthcare practice;
- Process claims/billing to your health plan, insurance company, or third party;
- Comply with laws that require reporting of your health information;
- Review your records for quality of care;
- Remind you of appointments;
- Inform you of any health services or benefit that may interest you;
- Use for research purposes
- Use for organ and tissue donation if you are an organ donor;
- Use as may be required by law;
- Avert a serious threat to health or safety.

YOUR RIGHTS: While the records we maintain about you belong to us, you have a number of rights with respect to those records. You have the right to:

- Request a copy of our full privacy notice
- See your record and request a copy;
- Request we amend your record if you believe it is not complete or correct;
- Request we send information to you in a confidential manner;
- Request a restriction or limitation on the health information we use or disclose about you;
- Complain to us and/or the US Department of Health and Human Services if you believe we have violated your privacy rights;
- Request a list of any disclosures not required for treatment, payment and business operations for a period of up to six years.

OUR DUTIES: We must provide you with our Notice of Privacy Practices and abide by its terms. We may:

- Charge a fee for copies of your medical information;
- Require up to 60 to 90 days to process your request for records;
- Deny your request to amend your records for certain reasons and if asked, give you a written reason;
- Amend the Notice from time to time, post the revised notice, and make a copy for you upon request.

If you have any questions, Please contact our Business Manager at 630-969-3233

Acknowledgements of receipt of this notice. We will request that you sign this term acknowledging that you have received a copy of this notice if desired. If you choose, or are not able to sign, a staff member will sign his or her name and date. This acknowledgment will be filed with your records

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

NEUROHEALTH ASSOCIATES

Statement Of Patient Financial Responsibility for Neurohealth Associates

Neurohealth Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment of any charges not covered by your insurer, payment of any deductibles, co-pays and co-insurances as determined by your contract with your insurance carrier.

**Neurohealth Associates will require a DOWN PAYMENT:** TO cover any portion of your deductible not met prior to services being rendered. Or a pay as go policy depending on your deductible amount until at which time your deductible is met.

**Commercial Insurance Carriers:** You are required to present a valid insurance card at every visit and as needed throughout your care. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of filing the claim, fees are due and payable in full from you. We understand that sometimes our patients may experience financial difficulties. If this should be the case, please communicate with our Financial Manager so that we may assist you in making payment arrangements. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered services will be due at the time services are rendered. A \$25.00 late fee will be incurred for any past due balances.

**Terms of Payment:** Payment is expected within 15 days of statement date. Any balances beyond 60 days will be referred to an outside collection agency. In the event that your account is turned over for collections then the patient or responsible party agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

**Medicare:** Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System) as well as secondary insurances that do not crossover. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered services will be due at the time services are rendered.

**Worker's Compensation:** If your visit is work-related we will need the case number and the carrier name, contact phone number, address and date of injury prior to your visit in order to bill the worker's compensation insurance company.

**Co-pay and Co-insurance Policy:** Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time of service at each visit. If your co-insurance is 50% we will require your co-insurance at the time services are rendered.

**Self-pay Policy:** In the event that I do not have health insurance, or that I know in advance that a specific service is not be covered by my insurance company, Or that NHA is not contracted and does not submit claims on my behalf, I will be responsible for payment prior to services rendered on the date of service at Neurohealth Associates. I agree to pay the full and entire amount at each visit. Neurohealth will assist to provide the information required to enable claims submission.

**Cancellation/No-show Policy** We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment. I understand that if I am a no show for any of my scheduled appointments, I will incur a fee of \$20.00 for each appointment missed, without notifying Neurohealth Associates 24 hours prior to my appointment time.

**Addendum Effective July 27<sup>th</sup> 2008:**We have recently instituted a \$80.00 technology surcharge/fee for the technology based portion of treatment (neurofeedback and biological feedback) which is due at the time of service, NO EXCEPTIONS. This is due to limitations imposed by insurance plans regarding such services. We appreciate your understanding. The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

Updated 09/30/09 Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_



**NEUROHEALTH ASSOCIATES**

**Date:** \_\_\_\_\_

**INSURANCE INFORMATION**

Patient's Full Name:

\_\_\_\_\_

Last	First	Middle Initial
------	-------	----------------

Responsible Party: \_\_\_\_\_

Primary Insurance Company Name: \_\_\_\_\_

Insurance customer phone number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

ID NO.: \_\_\_\_\_ Group No.: \_\_\_\_\_

---

**SECONDARY INSURANCE**

Secondary Ins. \_\_\_\_\_

Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

---

Other Insurance Information \_\_\_\_\_

I, hereby authorize Neurohealth Associates to release any and all medical information to the above named Insurance carriers or their representatives (and or attorney) for the purpose of claims consideration and evaluation review and financial audit. I further authorize any person or party responsible for the payments of my medical bill or any representative on their behalf to pay Neurohealth Associates directly for charges of services rendered to me. I agree to have my records faxed to any requesting legal agencies or insurance companies with the understanding that such faxed information may inadvertently be seen by a non designated party

*Parent/Guardian Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

**NEUROHEALTH ASSOCIATES**

**HEALTHCARE PROVIDERS**

Appointment Type (please circle):

NEW (Self referred) NEW (referred by healthcare provider) FOLLOW-UP

**\*\*Please note that we must have a referral if sent by another provider\*\***

**REFERRING PHYSICIAN**

Referring Physician Name: \_\_\_\_\_

Referring Physician Address: \_\_\_\_\_

\_\_\_\_\_

Referring Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

UPIN Number: \_\_\_\_\_ NPI Number: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

Primary Care Physician Name: \_\_\_\_\_

PCP Address: \_\_\_\_\_

PCP Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please list any OTHER Providers

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_





**Urinary Control Problems**

None Mild Moderate Severe

→

-----  
**Headaches**

None Mild Moderate Severe

→

**Chronic Pain:** Location \_\_\_\_\_

None Mild Moderate Severe

Location \_\_\_\_\_

None Mild Moderate Severe

**Abdominal-stomach discomfort**

None Mild Moderate Severe

**Appetite problems**

None Mild Moderate Severe

→

H/N/V/GI/A

**Sensory (Sensitivity) Problems**

None Mild Moderate Severe

**Problems falling asleep**

None Mild Moderate Severe

**Problems staying asleep**

None Mild Moderate Severe

A \_\_\_ V \_\_\_ T \_\_\_

**Daytime energy problems**

None Mild Moderate Severe

Slp-o – Slp-m

**Motivation problems**

None Mild Moderate Severe

Para-smns

-----  
**Social skills problems**

None Mild Moderate Severe

→

**Any developmental delays when you were a child in any of the following areas :**

- Speech – Language \_\_\_\_\_
- Motor-Balance-Coordination : \_\_\_\_\_
- Social-interpersonal: \_\_\_\_\_
- Intellectual: \_\_\_\_\_

→

**Incidents of mild or major head trauma (please list, including age)**

: \_\_\_\_\_

\_\_\_\_\_

**For office use only:**

→

**Incidents of loss of consciousness (please list, including age):**

\_\_\_\_\_

\_\_\_\_\_

→

**Stressful/Significant Life Events (e.g., loss of loved ones, injuries, accidents, relationship pain, etc.) ( please list, including age)**

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

→

**Alcohol Overuse/Abuse History:**                    \_\_\_ No  
   \_\_\_ Yes

→

→

**Prescription Medication Overuse/Abuse History:** \_\_\_ No  
   \_\_\_ Yes

→

**Recreational Drugs Overuse/Abuse History:**    \_\_\_ No  
   \_\_\_ Yes

**Cigarette Smoking:**                                    \_\_\_ No  
   \_\_\_ Yes

**For office use only:**

**Medications** (including dosage)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BIOLOGICAL MOTHER**  
If Living, Please list current age:            \_\_\_\_\_  
If Deceased, Please list age at death: \_\_\_\_\_

**Mother's Medical History:** \_\_\_\_\_

**Mother's Psychological History (depression, bipolar, alcoholism, anxiety, etc.)**

**BIOLOGICAL FATHER**

If Living, Please list current age: \_\_\_\_\_

If Deceased, Please list age at death: \_\_\_\_\_

**Father's Medical History:** \_\_\_\_\_

**Psychological History (depression, bipolar, alcoholism, anxiety, etc.)**

**Medical History of Biological brother(s)/sister(s), if applicable:**

**Have you had any previous Brain MRI, CT, fMRI, Brain Maps, or EEGs? Yes No**

Date/Findings: \_\_\_\_\_

**Previous Treatment(s) for the current symptom (please describe):**

**Typically, statistical analysis/interpretation of today's results and report generation require 7-14 days to complete. Testing is either completed in 1 or 2 appointments, depending on the evaluation conducted.**

**Would you prefer to receive:**

a phone message regarding today's results; Phone #: \_\_\_\_\_  
(is it permissible to leave a voicemail on this number? Yes or No  
(this allows for a verbal description of the findings and associated recommendations)

OR

a follow-up office visit to review results (this allows you to see the maps, data, and findings for a comprehensive discussion)

**In addition to the referral source (if applicable), who would you like a copy of the report sent to:**

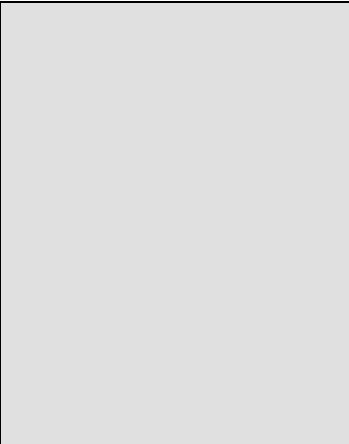
**For office use only:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_



(A) Notifier(s): Neurohealth Associates 477 E. Butterfield Rd Lombard IL 60148

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) 90901, 95957, 96118, 96119, 90804, 90806 below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) Services below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
90901 Neurofeedback 95952 95957 Brainmap 96118 and 96119 Testing  90804 Psychotherapy  90806 Psychotherapy  96118/96119 Testing	<b>Not a Medicare Covered Service</b> <b>Not a Medicare Covered Service</b> <b>You do Not have a Referral</b>  Medicare Takes an ADDITIONAL Reduction in Benefits For Mental Health Benefits (Member Responsible)  Medicare Takes an ADDITIONAL Reduction in Benefits For Mental Health Benefits (Member Responsible)  Medicare Takes an ADDITIONAL Reduction in Benefits For Mental Health Benefits (Member Responsible)	<b>\$80.00</b> <b>\$425.00</b> <b>\$1700.00</b>  <b>55% Coins.</b>  <b>55% Coins</b>  <b>55% Coins</b>

#### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- **Ask us any questions that you may have after you finish reading.**
- **Choose an option below about whether to receive the (D) Services listed above.**

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

#### (G) OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice **I am not responsible for payment, and I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:
----------------	-----------

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

## Authorization for Release of Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

I authorize the NHA  
to release information to:

I authorize the NHA  
to obtain information from:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone #/Fax # (Include area code)

\_\_\_\_\_  
Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one)  Healthcare  Insurance Coverage  Personal  Other

TYPE OF RECORDS AUTHORIZED:  Psychiatric/Psychological/Educational Evaluation and/or Treatment  
 Medical

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

Assessments  Progress Notes  Laboratory Test Results: \_\_\_\_\_

Diagnostic Impression  Discharge Summary  Treatment Plans

Treatment Summary

Other: (please describe) \_\_\_\_\_

**One-time Use/Disclosure:** I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

When the requested information has been sent/received.

90 days from this date.  Other: \_\_\_\_\_

**Periodic Use/Disclosure:** I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

**My authorization will expire:**

When I am no longer receiving services from the Neurohealth Associates.

One year from this date.  Other: \_\_\_\_\_

*I understand that:*

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to the NHA, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_