NEUROWEST NEUROPSYCHOLOGY
4001 Lake Otis Parkway, STE 201, Anchorage, AK 99508
P:(907) 615-3477 • F:(907) 615-3478 • NeuroWest.com

Registration Form

Patient: Full Name: _____ SSN: _____

DOB: _____/_____/_____ Cell/Home/Work (circle) Phone: _____

Mailing Address: _____

Physical Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Address (if different than above): _____

_____

Non-Insurance Billing (if applicable): □Self-Pay □DVR □Contract: _____ □Other: _____

Primary Insurance Information: Carrier: _____

Policy#: _____Group#: _____

Policy Holder's Name: _____SSN: _____DOB: ____/_____/_____

Secondary Insurance Information: Carrier: _____

Policy#: _____Group#: _____

Policy Holder's Name: _____SSN: _____DOB: ____/_____/_____

Tertiary Insurance Information: Carrier: _____

Policy#: _____Group#: _____

Policy Holder's Name: _____SSN: _____DOB: ____/_____/_____

I certify that the insurance information I have provided is true and accurate as of the date of signing and that I am responsible for keeping it updated. Please notify our office immediately if the patient changes insurance coverage during the course of services. My signature also serves as consent to be treated by NeuroWest Neuropsychology, LLC.

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

A photocopy of this document is considered to be as valid as the original.

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Credit Card Authorization Form

NeuroWest Neuropsychology, LLC provides a secure and convenient payment method for evaluations not covered by insurance companies and/or for the portion of services that your insurance does not cover but for which you are responsible. Your credit card information is kept confidential and secure. For evaluations where insurance will be billed, payments to your card are processed only after the claim has been filed to and processed by your insurance carrier and the insurance portion of the claim has posted to your account. In the event that valid insurance information was not provided at the time of service, or at the time of cancellation or no-show, in accordance with our Cancellation Policy below. If insurance will not be billed, then an estimation of cost will be provided upfront and due on the day of the evaluation. If there is additional payment due, it will be due the day of feedback or completion of the report if no feedback is requested. If there is any remaining credit once the service is complete, it will be credited back to the card upon completion of the service.

Cancellation Policy: Appointments must be canceled at least 72 hours in advance, or patients may be subject to a cancellation fee. If we do not receive notice at least 72 hours in advance and we are unable to fill your timeslot, you will be charged a $300 cancellation fee.

By signing below, you authorize NeuroWest Neuropsychology LLC to retain your credit card information in a secure method, and to charge that credit card for any amount owed on your account after insurance billing is complete (if insurance is available). If insurance is not billed, you authorize NeuroWest Neuropsychology, LLC, to charge that credit card for the estimated amount on the day of the evaluation.

You further agree that NeuroWest Neuropsychology, LLC may charge your credit card on file for all balances not covered by insurance or otherwise paid at the time of service. This could include but is not limited to cancellation fees, copays, deductibles, non-covered services or denials of coverage. This authorization is valid until written notice is provided to NeuroWest Neuropsychology, LLC at 4001 Lake Otis Parkway, STE 201, Anchorage, AK 99508-5211.

The person who signs below confirms that he/she is the authorized user of this credit card.

Patient Name: _____

Card Account #: _____

Card Holder's Name (as shown on card): _____

□ Visa □ Master Card □ Discover □ American Express Exp.(mm/yy): _____/_____ CVC: _____

Billing Address: _____

_____

Cardholder Signature: _____ Date: _____

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You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

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Authorization to Release Neuropsychological Report

Patient Full Name: _____ Date of Birth: _____

By signing this authorization, I authorize NeuroWest Neuropsychology to release reports and records to the following persons/organizations. If you would like reports mailed or sent by encrypted secure message and not faxed, please place this information under the address section. A copy will be sent to the referring provider.

Guardian/Self: _____

Phone: _____ Fax: _____

Address:

Primary Care Provider: _____

Phone: _____ Fax: _____

Address:

Psychologist or Mental Health Provider: _____

Phone: _____ Fax: _____

Address:

Occupational or Physical Therapist: _____

Phone: _____ Fax: _____

Address:

School or Other: _____

Phone: _____ Fax: _____

Address:

I understand that this authorization expires one year from the date the form is signed unless I submit a written request to the clinic prior to that date. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

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Neuropsychological Evaluation Informed Consent

Referral Source: A referral was made for a neuropsychological assessment by your provider, who determined it to be medically necessary.

Nature and Purpose of Assessment: Neuropsychological assessments identify difficulties in cognition, such as attention, memory, and problem-solving, and suggest potential treatments for rehabilitation, diagnostic clarification, and needed services. The process begins with a one-hour interview to collect background information. On a separate day testing will occur where a person does various tasks, such as answering questions, reading, drawing, solving problems, and manipulating objects. This evaluation does not establish an ongoing treatment relationship.

Foreseeable Risks, Discomforts, and Benefits: Assessments may cause fatigue, frustration, or anxiety, though these effects are expected to be minimal. We take care to reduce these as much as possible. Discuss any specific concerns with your provider. The benefits of a neuropsychological evaluation can include diagnostic clarity and the identification of appropriate and relevant treatment interventions and supports.

Consultation and Research: Case consultation with other licensed professionals may occur for various reasons, but no identifiable information will be shared. Additionally, your raw testing data may be de-identified and used for scholarly research to benefit others.

Fees and Time Commitment: The hourly flat fee for this assessment is $300. While we verify that no prior authorization is required, it is the duty of the responsible party to understand their deductible, co-pays, and co-insurance and how they may apply to this service. If you would like an estimate of cost, please request this in writing at info@neurowest.com. If this evaluation will not be billed to insurance or if we are not in-network with your insurance carrier, then a Good Faith Estimate will be provided ahead of time. If we are not a participating provider for your insurance plan, we will supply you with a receipt of payment for services after the service is complete (a “Superbill”), which you can submit to your insurance company for reimbursement. In these cases, payment will be required before services. Not all insurance companies reimburse out-of-network providers, and you must check with your insurance carrier to determine if this is a covered service. We can provide CPT codes if needed. If you prefer an in-network provider, contact your insurance company for a list of participating professionals. Any balance remaining after insurance reimbursement is your responsibility, as are any fees and reimbursement for time spent by office staff regarding disputed credit card charges. We may require a credit card to be held on file before obtaining services.

The initial interview is estimated to take one hour, testing can take up to eight face-to-face hours, and approximately eight hours are spent preparing the report. Once the evaluation is complete, feedback on the results will be offered, and this typically lasts one hour.

Release of Information: As documented in our Notice of Privacy Practices/Policy and Limits of Confidentiality, HIPAA permits us to correspond with treatment providers, including physicians involved in your care, for continuity of care, even upon rescinding signed Release of Information forms. If there is an objection to releasing information, a written request must be submitted to our office. Upon receiving it, we will review the request and decide if it is feasible and appropriate.

Subpoenas and Testifying in Court: Our practice does not conduct forensic or medicolegal evaluations. Should your provider be subpoenaed and required to testify in court, payment must be secured beforehand. Payment for services is charged on a full-day basis (9 hours) at $330 per hour. Travel time must also be reimbursed. Additional fees for court preparation will be charged on an as-needed basis.

I have read and agree with the nature and purpose of this assessment and with each of the points listed above. I have had an opportunity to ask and clarify all questions and discuss any points of concern before signing.

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

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Limits of Confidentiality

The information discussed in the neuropsychological or psychological evaluation will be incorporated into a final report. This report will be sent to the referring source and any other individuals/agencies identified on the Release of Neuropsychological Evaluation form signed during the first appointment. The patient may request that the final report be sent to another person or agency at any time in the future by completing an additional release form. If an insurance company or other agency is paying the fee for this evaluation, it may be necessary to send a copy of the report to that agency to secure reimbursement.

This report, and any other information discussed in the evaluation, is confidential, and it will not be shared without written permission except under the following conditions: 1) The patient threatens suicide; 2) The patient threatens harm to another person(s); 3) The patient reports suspected child abuse; 4) The patient reports abuse of the elderly.

State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies. Additionally, if the patient is involved in a legal action and claims mental health issues related to the legal action (i.e., a plea of “Not Guilty by Reason of Insanity” or claiming emotional harm in a lawsuit), mental health records may be required to be released. Finally, there may be other situations where release is permitted by law, but NeuroWest Neuropsychology, LLC will limit such release to the minimum necessary to meet the legal requirements. Communications between NeuroWest Neuropsychology, LLC, and the patient will otherwise be deemed confidential as stated under Alaska state law.

I have read and understand the above information, and I agree to the limits of confidentiality.

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

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No Show/Missed Appointment Policy

We understand that sometimes you need to cancel or reschedule an appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible within business hours (with at least a 72-hour notice). You can cancel appointments by calling (907) 615-3477.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. To ensure attendance, we have a late cancellation policy of $300 for the testing appointment.

Please Review the Following Policy:

1. Please cancel your appointment with at least 72 hours' notice: There is a waiting list to see the clinicians at NeuroWest Neuropsychology, LLC. Whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.
2. If less than a 72-hour cancellation is given, this will be documented as a “Late Cancel” appointment, and the fee will be charged. If you do not present to the office for your appointment, this will be documented as a “No-Show” appointment.
3. If you have 2 "No-Show/Missed" appointments within a one-year time, dismissal from the practice will be considered.

I have read and understand NeuroWest Neuropsychology, LLC’s No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty keeping my scheduled appointments.

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

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HIPAA Notice of Privacy Practices and Policy - Effective Date: 07/23/2024

This Notice of Privacy Practices describes how we safeguard, use, and how you can access your Protected Health Information ("PHI"). Please review it carefully. If you have any questions, please contact Michael Arnatt, the owner of NeuroWest Neuropsychology, LLC. A summary of the HIPAA Privacy Rule can be found at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

NeuroWest Neuropsychology, LLC is committed to protecting the privacy and confidentiality of your medical information. This Notice of Privacy Practices describes some of our policies on how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations and for other purposes permitted or required by law. It also describes your rights to access and control your PHI. Each time you visit NeuroWest Neuropsychology, LLC, a record of your visit is made. This record typically contains your symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment.

How We May Use and Disclose Your Health Information

Our Responsibilities: NeuroWest Neuropsychology, LLC is required by law to maintain the privacy of your PHI, to provide you with this Notice of our legal duties and privacy practices, and to abide by the terms of the Notice currently in effect. Your Protected Health Information may be shared in the following ways as provided by law. Any exceptions require your written permission, which may be revoked by writing to us at any time.

Appointment Reminders: Our policy is to remind you of appointments with us. We may do this by telephone, answering machine message, email, U.S. mail/postcard, or by any means convenient for the practice and/or as requested by you.

Billing and Payment: We may use and disclose PHI about you so that the treatment and services you receive at our practice may be billed to and payment collected from you, an insurance company, or a third party. For example, we may give your health insurance company information to obtain coverage information.

Business Associates: We may disclose your health information to our business associates who perform functions on our behalf or provide us with services if necessary. For example, our technical support crew will have access to your information while working on our medical record software. All of our business associates are obligated to protect the privacy of your information. They are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Health Care Operations and Research: We may use and disclose PHI about you for operational purposes. For example, we may use PHI to evaluate the quality of care you receive or to conduct internal audits and compliance reviews. PHI may be used in training programs for students, trainees, or other personnel to help them learn or improve their skills. We may also use your information to support external or internal research on matters of medical importance, provided that an authorized governing body certifies that your health information will remain private. We may not otherwise use or sell your PHI without your express written authorization.

As Required by Law: We may disclose your health information when required to do so by international, federal, state, or local law or when necessary for health care oversight. For example, if you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order, subpoena, discovery request, or other lawful process as required. This includes, but is not limited to (a) reporting suspected child abuse or neglect; (b) the court ordered to release information; (c) the legal duty to warn or take action regarding imminent danger to others or to a specific place; (d) if an individual is a danger to self or others or is believed to be gravely disabled; (e) to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance; (f) to authorized federal officials for intelligence and other national security activities authorized by law; (g) the information is relevant to criminal conduct on our premises; or (h) to health

oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

Treatment: We may use PHI about you to provide, coordinate, or manage your health care and related services. For example, your PHI may be used to develop a treatment plan for managing memory loss or cognitive impairment. Our staff may discuss your condition and treatment options with other healthcare providers involved in your care.

Your Rights Regarding Your PHI

You have the following rights regarding the PHI we maintain about you, and written requests will be honored within three business days.

A Copy of This Notice: You have the right to a paper or electronic copy of this notice upon request.

Access: You have the right to inspect and obtain a copy of PHI that may be used to make decisions about your care. This includes medical and billing records. You may request a list of instances where we have shared your PHI with third parties for purposes other than treatment, payment, or healthcare operations.

Accounting of Disclosures: You have the right to receive an Accounting of certain disclosures the Practitioner has made regarding your Protected Health Information. However, that Accounting does not include disclosures that were made for Treatment, Payment, or Health Care Operations. To make a request, contact us in writing.

Amendment: You have the right to request an amendment to your medical records. This request must be in writing. If your amendment request is denied, you may make a written statement of disagreement and will receive a copy of our response.

Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or location. You can ask, for example, that we contact you only by phone or while at work. Your written request must specify how or where you wish to be contacted and be addressed to NeuroWest Neuropsychology, LLC and we will accommodate reasonable requests.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at NeuroWest Neuropsychology, LLC, or the Department of Health and Human Services Secretary. All complaints must be submitted in writing. You will not be retaliated against or penalized for filing a complaint. The Secretary of DHHS can be reached at The Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue. S.W. Room 509F, HHH Building Washington, D.C. 20201

Notification of Breach: It is the legal duty of NeuroWest Neuropsychology, LLC, to notify you in the event your PHI is compromised without your permission.

Restriction Request: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about an assessment you had. We are not required to agree with your request, but we will try. You also have the right to restrict disclosure of your PHI to your health insurance carrier if you pay NeuroWest Neuropsychology, LLC in full (“out of pocket”) for services rendered.

Changes to this Notice: NeuroWest Neuropsychology, LLC reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you and any information we receive in the future. We will post a copy of the current Notice in our office and on our website. You may request a copy of our most current Notice at any time.

If you have any questions or concerns about this Notice or how your PHI may be used or disclosed, please contact Michael Arnatt, PsyD at NeuroWest Neuropsychology, LLC.

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HIPAA Acknowledgement, Assignment of Benefits, and Office Policies

_____ (initial). I acknowledge receipt of NeuroWest Neuropsychology, LLC's HIPAA Notice of Privacy Practices/Policy and recognize that changes to this policy may occur at any time without notice. I may request a written copy at any time.

_____ (initial). I consent to treatment and evaluation by NeuroWest Neuropsychology. I have had the opportunity to ask questions related to my care and acknowledge that I can ask any questions and concerns as they present during the assessment process.

_____ (initial). I authorize NeuroWest Neuropsychology, LLC, to submit claims to my insurance company(s) on my behalf and my insurance company(s) to pay benefits directly to NeuroWest Neuropsychology, LLC. I hereby authorize benefits to be assigned to NeuroWest Neuropsychology, LLC. I certify that the insurance information I have provided is true and accurate as of the date of service and that I am responsible for keeping it updated.

_____ (initial). I commit to canceling appointments with a minimum of 72-hour notice during business hours and understand that failure to notify this office of my inability to keep any appointment will result in a "no-show." No-shows are serious and may involve a fine that must be paid prior to being seen again in this clinic, pursuant to the clinic No-Show Policy, which I have received. Insurances do not cover no-show charges. Patients over 15 minutes late to an appointment may be asked to reschedule.

_____ (initial). I understand that should any insurance payment be made directly to me for monies due on this account, I agree to immediately pay these funds to NeuroWest Neuropsychology, LLC. I will be responsible for the amount due until payment is made in full.

_____ (initial). I understand that an "out-of-network" insurance carrier may limit payments for any or all services provided by NeuroWest Neuropsychology, LLC, regardless of the advertised benefits package (that is, they may pay less than our standard charges, even if they advertise "100% benefit").

_____ (initial). I agree that upon acceptance of services provided by NeuroWest Neuropsychology, LLC, I assume responsibility for any deductible, co-pay, coinsurance, and any other balance not covered by my insurance carrier. Copays and estimated coinsurances are due at the time of service. If my account is turned over for collection, I agree to pay any resulting collection and legal fees.

_____ (initial). I also acknowledge that pursuant to Ethical Standard 9.04 Release of Test Data, that "psychologists may refrain from releasing test data to protect a parent/patient or others from substantial harm, misuse or misrepresentation of the data or the test, recognizing that in many instances the release of confidential information under these circumstances is regulated by law." NeuroWest Neuropsychology, LLC's standard policy is that raw test data will not be released to anyone other than a licensed professional Neuropsychologist qualified to interpret the data. This request must be made in writing.

I certify that I have read and understood the information provided above:

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

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