San Mateo Memory Center
411 Main St. Half Moon Bay, California 94019
Website: www.drmichaeldebellis.com
Main phone #: (510) 316-4364
Fax #: (877) 879-7892

PATIENT INFORMATION FORM

Patient Name: _____ Date: _____

Patient's Date of Birth: _____ Social Security Number: _____

Patient's Address:_____

Home Phone: _____ Alternate Phone: _____

Is it okay for us to leave messages for you at these numbers regarding your appointments? Yes/ No

Alternate Contact: _____

Relationship to Patient: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

Is it okay for us to leave messages for you at these numbers regarding your appointments? Yes/ No
Emergency Contact (check if same as above)

Name: _____ Phone: _____

Who referred you to our office? _____

Who is your primary care doctor? _____

I acknowledge the above information is correct to the best of my knowledge.

_____ _____

signature date

San Mateo Memory Center

STATEMENT OF INFORMED CONSENT

Nature and Purpose of Assessment: The goal of neuropsychological assessment is to determine if any changes have occurred in your attention, memory, language, problem solving or other areas of cognitive functioning. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your background and current medical symptoms, we may be using different techniques and standardized tests including, but not limited to, asking questions about your knowledge of certain topics, reading, drawing figures and shapes, working on a computer, viewing printed material and manipulating objects. For some individuals assessment can cause fatigue, frustration and anxiety.

Limits of Confidentiality: The health Insurance Portability and Accountability Act of 1996 (HIPAA) established a privacy rule to ensure that health care providers obtain adequate consent from their patients for the use and disclosure of health information to carry out treatment, payment or health operations.

We at the San Mateo memory Center do all we can to secure and protect your privacy, providing only the minimum necessary information to those who are in need of your information regarding treatment, payment or health care operations. Information obtained during assessment is confidential and can ordinarily only be released with your written permission. There are some special circumstances that can limit confidentiality, including: a) a statement to harm self or others, b) statements indicating harm or abuse to children or vulnerable adults, and c) issuance of a subpoena from a court of law.

You may refuse to consent to the use or disclosure of your personal health information, but you must do so in writing. Under HIPAA, we have the right to refuse to treat you, should you refuse to disclose your personal health information as outlined above. If you choose to give consent in this document, at some future time you may request to refuse disclosure of all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or any previously signed consent.

I hereby consent to the use or disclosure of my protected health information as specified above.

Print Name

_____

Signature _____ Date _____

San Mateo Memory Center

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize Dr. DeBellis and staff at the San Mateo memory Center to release the following protected health information (PHI) from my clinical record:

- O Neuropsychological Report
- O Post-Concussion Consultation Report
- O Other: (Please Specify) _____

I authorize information regarding my care to be released to the following individuals:

- O Primary Care Provider
- O Referring Provider (If different)
- O Spouse
- O Other Family Members: (Please Specify) _____
- O Other Professions: (Please Specify) _____
- O I request that a copy of the report be sent to me (the patient).

I would like to put the following limitations on this release: (Specify below)

_____

_____

This authorization shall remain effective until:

- O The termination of treatment
- O Expiration date determined by patient (Please Specify) _____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation to the San Mateo memory Center office address. Notice of revocation will not be effective until received by the San Mateo Memory Center. I also understand that the purpose of this release is to assist with the facilitating communication between profession service providers, agencies or other individuals named in this document. I understand the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these risks. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

Signature _____ Date _____

Signature of Patient Representative (if applicable) _____

If a patient representative signs this authorization form, a description of such representative's authority to act for the patient must be provided.

San Mateo Memory Center

STATEMENT OF FINANCIAL RESPONSIBILITY

Please read and sign this form that outlines financial responsibility for treatment:

1. The patient/guardian is financially responsible for services received. You are responsible for informing us of any changes to your insurance coverage.
2. The financial responsibility can be met if insurance benefits cover services rendered. Covered services vary by insurance plan; it is your responsibility to understand the benefits and requirements of you specific plan. You may be required to obtain pre-authorization and/or a physician referral; denial by your insurance company due to lack of these is your responsibility. You may be required to pay a portion of fees due to a deductible or co-payment as dictated by your insurance. You agree to assign any monies due and payable to the insurance company for these services to our facility. A copy of your charges, if requested, will be supplied to you so that you may follow up with your insurance company personally.
3. Payment by your insurance company is often to an evaluation for medical necessity as determined by your insurance company. Services specifically requested for or related to a job, education or legal proceedings many not be covered.
4. If you choose to use insurance benefits to pay for services, we will be required to provide information to the insurance company. This is likely to include diagnoses, symptoms and treatment plan, though other information may be required. Once information leaves our office we cannot control how it is used. If you choose not to share information with your insurance company, you may not receive reimbursement for the services you are receiving.
5. Payment is expected at time of service unless specific arrangements are agreed upon in advance. We are willing to work with you to set up a payment plan for any amounts not paid by your insurance. Finance charges of 1.5% will be charged each month for unpaid balances over 30 days (18% annual percentage rate). If a balance remains unpaid for an additional 30 days, your account may be referred to a collection agency. Any fees for additional collections will be added to your balance.

6. If you request copies of information sent to another source or if you have given another source permission to review evaluations or other reports, there may be a charge for copying and mailing. If letters are written on you behalf, or extended or frequent telephone calls or e-mails made, additional hourly rates for services may apply for time over 10 minutes. Hourly rates are $250/hour for assessments and $150/hour for treatment.
7. A minimum of 48 hours' notice is required for cancellation of appointments as we set aside a substantial block of time for your evaluation. If this notice is not received, you may be charged for the full cost of the missed appointment. Insurance will not be billed for cancelled/ missed appointments.
8. We will file a claim with your insurance as a courtesy to you; we do not guarantee that service will be covered or at what percentage it may be covered. Insurance typically pays 50%-80% of our services if deemed medically necessary. Co-payments, deductibles, and non-covered services are payable at the time of service.
9. Neuropsychological evaluation and testing includes time for administering and scoring tests clinical interview, interpretation of data, review of records, conferring with other providers/parties, preparing report and discussion of the results. All of these aspects typically add 1-6 hours to the actual testing time that you spend in our clinic.
10. We are participating providers with Medicare, which means that we accept Medicare assignments as payment in full, once your deductibles and co-payments have been made. We will bill Medicare for you, as well as your supplemental insurance carrier. You must provide valid cards from Medicare and other insurance carriers. Without these we cannot bill, and payment will be at the time of your visit.
11. For your convenience, we accept cash, checks and credit cards. Please make your check payable to San Mateo Memory Center. A $25 charge will apply on all returned checks.
12.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____Date: _____