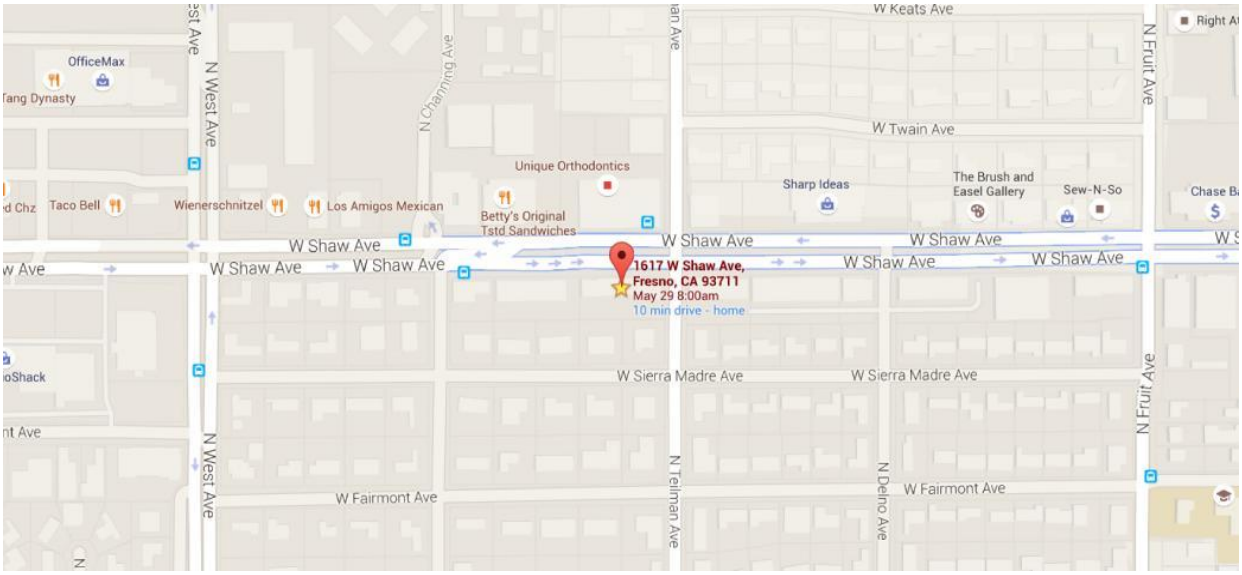
Kathleen L. Munsell, PhD, MS

www.CentralValleyNeuropsychologicalServices

1617 W. Shaw Ave, Suite E
Fresno, CA 93711
drmunsell@gmail.com

Phone: 559-475-0210
Fax: 559-475-0779
Text: 559-588-4878



I would like to welcome you to my practice and am pleased to have you as a patient. I am providing you with this informational letter to help you understand how this office operates. Every effort will be made to treat you with courtesy and respect. Please read this information carefully and write down any questions that you might have so that you can discuss them with me during your first appointment.

GENERAL INFORMATION

Our office is located on the southwest corner of Shaw Ave. and Teilman between Fruit and West.

Please arrive with your paperwork completely filled out (**PRIOR TO YOUR ARRIVAL**), along with your insurance card(s) and any other paperwork requested by our office. **If your paperwork is not completed prior to your office visit, your scheduled time will be spent filling out your paperwork and will be considered part of the office visit.** Office visits are 45 to 50 minutes in duration, unless you have been told otherwise. This office does not have front office personnel, please be seated in the waiting area and Dr. Munsell will come out to see you when she has finished the session prior to yours.

If you have any questions, please feel free to contact our office at 559 475-0210.

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CANCELLATIONS

When you schedule an appointment, that time is reserved specifically for you. **It is your responsibility to remember and keep scheduled appointments. A minimum of 24 hour notice** is required if you are canceling or re-scheduling an appointment.

You will be charged **$100.00** for missed appointments and appointments which are canceled with less than 24 hour notice. IN the case of evaluations where multiple hours of testing have been scheduled, you will be charged **$100.00/hour.**

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this Cancellation Policy.

Signature: _____ Date: _____

EMERGENCIES

If you need to contact Dr. Munsell between sessions, please leave a message via text at 559-579-7413, e-mail her (drmunsell@gmail.com), or leave a message on the office phone 559-475-0210 and she will respond as soon as possible. If an emergency situation arises, please indicate that, "this is an emergency" when leaving your message. **Calls made between 3:00 p.m. and 9:00 a.m. should be of an urgent or emergency nature only**.

In the event that Dr. Munsell is unavailable due to illness, vacation, or other circumstances, emergency calls will be forwarded to the doctor that has agreed to handle crisis calls for her. In the even that Dr. Munsell or the doctor on call is unable to be reached, then free emergency evaluations can be obtained at Community Behavioral Health Center, 7171 N. Cedar Ave., Fresno, CA, (559) 449-4434. For children and adolescents, call the CCAIR unit at (559) 453-3860. **Otherwise, for any life threatening emergency, you should call "9-1-1" to access emergency medical services.**

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this Emergency section.

Signature: _____ Date: _____

FINANCIAL AGREEMENT & OFFICE BILLING/INSURANCE POLICIES

I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of treatment or an evaluation are reimbursed by insurance companies**. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any non-covered services or services determined not to be Medically Necessary by my insurance.** I understand that this office

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does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.
It is your responsibility to contact your insurance company to open your case, acquire pre-authorization for treatment, and confirm benefits for "Outpatient Mental Health" services before your first appointment. Be sure to state that this is for **"outpatient mental health"** benefits; otherwise the insurance personnel may quote you the benefits for major medical services instead.

It is our office policy that you provide us with payment in full at the time of the first visit, unless you are part of an HMO/PPO that provides us with a specific co-pay amount which you are required to pay at the time of service. Otherwise, please contact our office in advance of your appointment to be told the exact amount you will need to pay at the time of your first visit. We will bill your insurance and, if they pay for your services, we will apply initial payment towards your account.

I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

I understand that if my insurance(s) require a referral from my primary care physician, Dr. Munsell must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance cards(s) to my first appointment so that the office can properly identify my program(s).

If my sessions are to be billed to **Worker's Compensation**, I will provide the name of my carrier, the address where the billing is to be sent, my claim/case number, the name and phone number of my case worker, and a copy of the"Employee's Claim for Worker's Compensation Benefits" (DWC Form 1).
I understand that I will receive a statement if I have an outstanding balance on my account and I am to pay any portion that is my responsibility within 15 days of receipt of a statement. A finance charge of 1% per month may be added to my account if payment is overdue.

I understand that there will be a $25.00 service fee for any checks returned by my bank due to non-sufficient funds, closed accounts, etc. I agree to accept full responsibility for such fee. The amount of the returned check, plus the service fee, must be paid within 10 days of written notice.
There will be no charge for releasing records to other treating medical or mental health professionals. For all other requests to copy records there will be a minimum charge of $25.00 to cover the expenses of photocopying, postage and handling.

I will notify the Office Manager if any problem arises regarding my ability to make timely payments. If my account is overdue (unpaid) and there is no agreement on a payment plan, I understand that this office can use legal means (court, collection agency, etc.) to obtain payment.

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this Financial Agreement and Office Billing/Insurance Policies.

Signature: _____ Date: _____

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AUTHORIZATION FOR CREDIT CARD

Please do not alter or change this authorization form. For additional information, please see our Frequently Asked Questions Document

NOTE: We do not keep any credit card information on file, in our office, or on any computer we have. We use a secure gateway that is completely compliant as required by law.

AUTHORIZATION:
Until further notice, I authorize Kathleen L Munsell, PhD to charge the patient-responsible balances on my account to the following credit card:

Check one: ☐ Visa ☐ MasterCard ☐ Discover ☐ HSA/FSA

Last Four Digits of Credit Card Number: ___ ___ ___ ___

Exp. Date (mm/yy): ___/___

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Kathleen L Munsell, PhD may charge my credit card the balance due when they receive a copy of the EOB. I also understand that Kathleen L Munsell, PhD may charge my credit card any open balance due as well, if they determine that a prior balance exists.

Signature: _____ Date: _____

Printed Name: _____

E-mail (required to provide payment notification): _____

Patient Name (if different than above): _____

Patient Date of Birth: ___/___/___

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FREQUENTLY ASKED QUESTIONS

Is this something New? I've never had to do this before.	**Due to the high number of deductible plans, and higher patient coinsurance benefits, this has become necessary at our practice. Please keep in mind, we will not charge your card if you do not owe anything.**
How can I trust that you will keep my credit information safe?	We do not keep any credit card information on file, in the office, or on any of the computers we have. We use a secure gateway that is completely compliant as required by law.
Ho much are you going to charge my card?	We will charge your card in accordance with what your insurance company tells us is your responsibility. We send out an e-mail notification prior to your card being processed to let you know how much you will be charged. We will make all best attempts at getting this e-mail to you, so please be sure that your most updated email address is currently on file at our office.
Which credit cards do you accept?	We accept all major credit cards, including Visa, MasterCard, and Discover, along with FSA, HSA and debit cards.
Will you send me a bill to let me know what I owe?	After your appointment, you will receive an EOB that will tell you what you are responsible for. We receive the same letter within 20-30 days following your appointment. We will review each EOB carefully and charge your credit card with the amount that is determined by your insurance to be your responsibility. We will send out an e-mail notification prior to your card being processed to let you know how much you will be charged.
What is a deductible and how does it affect me?	An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins. For example, if your policy has a $500 deductible, you must pay the first $500 of medical expenses before you insurance company begins to pay for any services. This works in the same method as the deductible for your car insurance or homeowner's insurance policy.
When does a deductible begin?	Your deductible begins at the start of your plan each year. Plans can start on any date but typically plan years begin either on January 1st or July 1st.
How will I know when my deductible has been met?	You may find out when your deductible has been met by calling your insurance company at anytime. Some insurance companies also have this information available online.
What happens if I do not have a credit card?	If you do not have a credit card or debit card, we can accept a $250 deposit at check in before your appointment.
What happens if I need to dispute my bill?	We will always work with you to determine if there has been a mistake on your bill, and we will refund you if we have mad a billing error. We will only charge you the amount that we are instructed to by your insurance carrier in your Explanation of Benefits, no show charges incurred, or miscellaneous paperwork fees that you have agreed to beforehand.
Does my doctor know you are doing this?	Yes
I've always paid my bills on time. Why do I have to give you a credit card?	Due to the complexities of the current healthcare laws, we take this approach with all of our patients.
I have dual insurances and I am covered at 100%, so I will never have a charge. Do I still need to give you a credit card?	Even with dual insurances, there are often times a patient still has some responsibility. Please keep in mind, we will not charge your card if you do not owe anything.

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PATIENT CONSENT

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you (a copy of this notice is provided to you in the waiting room of the office). The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change over time. If we change our Notice, you may obtain a revised copy by contacting me at (559) 475-0210, or by visiting our website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosure we have already made in reliance on your prior Consent. Kathleen L. Munsell, PhD provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient's Signature: _____

Relationship to Patient if not the Patient's Signature: _____

Print the Patient's Name:_____

Kathleen L. Munsell, PhD (signature):_____

Date of Execution: _____

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PAYMENT AGREEMENT/AUTHORIZATION TO BILL INSURANCE

PATIENT NAME: _____

I request that payment of authorized medical services furnished to me or my minor child be made by my insurance company on behalf of mine or my minor child's behalf to the provider of services indicated above. I authorize the medical provider listed and her agents to release any information concerning my medical care to my insurance company and any of its agents for the sole purpose of determining benefits payable on my or my child's medically related charges.

I understand my signature on this form authorizes my insurance company to make payment directly to the provider referenced above and that I am authorizing my provider to release my insurance company to make payment directly to the provider referenced.

If Dr. Munsell is not a participating provider, then I, as the patient or responsible party, understands the charges in full is my sole responsibility **AND ARE PAYABLE AT THE TIME OF EACH SERVICE.**

This policy applies to secondary and subsequent plans as well.

I understand this to be a lifetime beneficiary insurance authorization, unless I cancel this authorization in writing.

Primary Insured's Signature: _____ **Date:** _____

Secondary Insured's Signature: _____ **Date:** _____

CONSENT FOR TREATMENT

I understand that Kathleen L Munsell, PhD is a mandated reporter. A mandated reporter is not only responsible for the patient's safety but the safety of the public in general. What that means is that if a patient tells her that they have been sexually, physically, or verbally abused, she must report that to the proper agency. In addition, if the patient tells her that they have abused another individual, or is planning to harm another individual, of any age, she must report them to the authorities. Finally, if the patient tells her that they are suicidal, she will first assess the risk and then take the proper steps to protect the patient, up to and including involuntary hospitalization.

I understand what a mandated reporter is and the responsibilities of that individual.
I hereby authorize Kathleen L. Munsell, PhD, MS to myself, my minor child, or my dependent.

Signature: _____ **Date:** _____

PATIENT AND BILLING DATA

Patient Information:

Name: _____ _____ _____ Mobile Phone: _____

Nickname: _____ Home Phone: _____

Date of Birth: _____ Work Phone: _____

Gender: ☐ Male ☐ Female Other Phone: _____

Marital Status: ☐ Married ☐ Single ☐ Other E-Mail: _____

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed/Other

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Insured's Information:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Life Partner ☐ Other: _____

Name: _____ Mobile Phone: _____

Date of Birth: _____ Home Phone: _____

Gender: ☐ Male ☐ Female Work Phone: _____

E-Mail: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Secondary Insured's Information:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Life Partner ☐ Other: _____

Name: _____ _____ _____ Mobile Phone: _____

Date of Birth: _____ Home Phone: _____

Gender: ☐ Male ☐ Female Work Phone: _____

E-Mail: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Relationship to Patient: _____

Name: _____ Phone: _____

PATIENT AND BILLING DATA (cont.)

Primary Care Physician's Information:

Name: _____ Office Phone: _____

Release of Information Signed: ☐ Yes ☐ No Office Fax: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Psychiatrist's Information:

Name: _____ Office Phone: _____

Release of Information Signed: ☐ Yes ☐ No Office Fax: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Worker's Compensation Claims (please complete the following):

Referring Provider: _____ Referral Number: _____

Insurance Carrier: _____ Referral Date: _____

Insurance Case Worker: _____ Referral Expires: _____

Starting Date of Current Illness: _____ Date of Similar Illness: _____

Ability to Work: Patient was unable to work from _____ to _____

Hospitalization: Patient was hospitalized with this illness from _____ to _____

Causes of Patient Condition:

☐ Condition is related to current or previous employment

☐ Condition is related to an auto accident

☐ Condition is related to an accident (not auto)

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AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, hereby request and authorize information and records, as described below, to be released

[☒to/☒ from]: _____

[☒ to/☒ from]: **Kathleen L. Munsell, Ph.D., M.S.**

I understand that the medical records and information to be released may contina information pertaining to mental health, drug and/or alcohol related treatment, personal and family information, and delinquent and/or adult criminal history. Additionally, results from psychological and neuropsychological testing may also be released. It may also contain related medical information, including test results from medical laboratories.

The disclosure of records and information authorized herein is required for the purpose of treatment and/or completing a comprehensive evaluation.

I specifically request that the following records be released.

- ☐ History and Physical Examination
- ☐ Menalth Health Evaluation
- ☐ Consultation Reports
- ☐ Psychological Testing Results
- ☐ Neuropsychological Testing Results
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ HIV Related Diagnosis/Treatment
- ☐ Family History
- ☐ Progress Notes
- ☐ Physician Orders
- ☐ Medication Administration Records
- ☐ School Records (Grades, State Tests, etc.)
- ☐ Confidential School Records (IEP's, etc.)
- ☐ Radiology and EEG Reports
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Other: _____
- ☒ All of the above

This authorization is subject to revocation by the undersigned at any time except to the extent that action based on my authorization has already been taken. I understand that revocation must be in writing. A copy of this authorization/request is to be as valid as the original.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This authorization/consent is given freely and I have not been threatened with discontinuance or refusal of service if I do not sign this form.

I agree that above persons/organization may Fax or E-mail the above records.

_____ _____
Name of Patient — Patient's Date of Birth

_____ _____
Patient's Signature (**IF ADULT**) — Date Signed

_____ _____
Guardian/Legally Authorized Representative of Patient — Date Signed