NEUROPSYCHOLOGIC ASSOCIATES, PLLC

Notice To All **Patients:**

I understand that ***24 hour notice*** is required to cancel an appointment.

In accordance with my Insurance Carrier's policy, I understand that I will be responsible for the ***co-payment for the visit*** unless I provide 24 hour notice of my intent to cancel.

I have read this notice and understand its content.

____________________________ ________________________

Patient's Signature Date

98 PARK AVENUE • BABYLON, NY 11702

PHONE: (631) 482-1200 • WWW.NEUROPSYCHLI.COM • FAX: (631) 482-1203

NEUROPSYCHOLOGIC ASSOCIATES, PLLC

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and individuals also described below.

Description of the specific information to be used or disclosed:
All personal and medical information.

Person or entity requesting the information and authorized to make the requested use or disclosure: all hospitals, physicians, labs, and any others with whom my care is coordinated

Recipient of the information: ______________________________

This information is being requested for the following purpose(s): treatment, coordination of care, and payment.

This authorization shall remain in effect from the date signed below until five (5) years from the date of this patient's signature.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed;
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer;
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA;
- I may refuse top sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide the research-related treatment).

☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name:____________________ Signature:____________________

Relationship to Patient (if signed by personal representative of Patient):__________

Date:__________________

98 PARK AVENUE • BABYLON, NY 11702

PHONE: (631) 482-1200 • WWW.NEUROPSYCHLI.COM • FAX: (631) 482-1203

NEUROPSYCHOLOGIC ASSOCIATES, PLLC

Notice of Privacy Practices Acknowledgment

I understand that, under the *Health Insurance Portability & Accountability Act of 1966* (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third party payers;
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:____

Relationship To patient:_______________________________________

Signature:____

Date:____

(A detailed explanation of Privacy Practices may be found at our website.)

Office Use Only: I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:______ Initials:_____ Reason:_______________________________

98 PARK AVENUE • BABYLON, NY 11702

PHONE: (631) 482-1200 • WWW.NEUROPSYCHLI.COM • FAX: (631) 482-1203

NEUROPSYCHOLOGIC ASSOCIATES, PLLC

Patient Information Sheet

Please fill out this form completely, write N/A where applicable, and sign it. Thank you.

Referral Source:____________________

Do you have Medical Insurance: (Please check) Yes____ No____ Patient's Sex: Male___ Female___

What is your relationship to the policy holder? Self____ Spouse_____ Other_____

Patient's Social Security #____________-__________-__________

Patient's Name: Last________________ First________________ Middle__________

Street Address:____

City:____________________ State:__________

Zip:______________

Home Telephone: (_____) _____-_________ Work Telephone: (____) _____-____________

Cell Phone: (_____)_______-___________

Age:__________ Patient's Date of Birth: ______________________

Is Patient Married?__________ Name of Spouse:____________________

Emergency Telephone Number: (_______) ____________-______________

PATIENT'S INSURANCE INFORMATION

Primary Insurance Company Information:

Company Name:____________________

Address:____________________

Insurance #____________________

Groups #____________________

Do you have a co-pay?______ Amount: $_____

Policy Holder Information

Policy Holder's SS#______________

Address:____________________

City:__________ State:_____ Zip:______

Policy Holder's Date of Birth:__________

Secondary Insurance Company Information

Company Name:____________________

Address:____________________

Insurance #____________________

Group #____________________

Do you have a co-pay?______ Amount: $______

Policy Holder Information

Policy Holder's SS#______________

Address:____________________

City:__________ State:________ Zip:____

Policy Holder's Date of Birth:__________

Pharmacy:____

I hereby authorize the release of any medical information necessary to process this claim and hereby assign Neuropsychologic Associates, PLLC all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Patient's Signature:________________________ **Today's Date:**______________

98 PARK AVENUE • BABYLON, NY 11702

PHONE: (631) 482-1200 • WWW.NEUROPSYCHLI.COM • FAX: (631) 482-1203