Neuropsychology Consultants

6717 W. Eldorado Parkway, Suite 110
McKinney, TX 75070

214-585-0584 (phone) 214-585-0586 (fax)
www.npconsult.net

Child and Adolescent Information

Date _____

Child's Name _____ Gender _____

Age _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____

Phone (Preferred):_____ (Secondary):_____

Referred by _____

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Does the child live in the home with both of his or her biological parents? _____

If not, which parent(s) have the right to consent to medical and/or mental health treatment? _____

Please provide documentation of custody or guardianship arrangements, as applicable

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Mother's Name _____ DOB _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Father's Name _____ DOB _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Consent for Treatment – Child or Adolescent

I give my consent for my child or adolescent to receive psychological and/or neuropsychological services from clinicians of Neuropsychology Consultants.

I understand that services are provided on a confidential basis and records are disclosed only when properly authorized or required by law.

I understand that payment for services is due at the time of service, and that my appointment will need to be rescheduled if I am unable to fulfill this obligation.

I acknowledge that I have had an opportunity to review the HIPAA Privacy Policy Form utilized by Neuropsychology Consultants.

This authorization shall remain in effect for one year from the date of signing or until_____.

_____

Child or Adolescent's Name

_____ _____

Signature of Parent or Legal Guardian Date

If signed by a guardian, please state legal basis for guardian status: _____

Information Regarding Payment for Services

The parent's portion of payment for the requested services is due on the date services are rendered. If services are paid for by check and the check is returned as not paid, there is a $35 returned check fee. If we are in-network with your insurance company, we will check your benefits and relay to you the information they provide regarding co-pays, co-insurance, and deductibles. You may want to verify this information for yourself, as insurance companies sometimes handle claims differently than what they quoted initially. We will file your claim according to their requirements.

Please be aware that insurance companies will only cover medically necessary services; they do not consider academic testing medically necessary and will not pay for this type of testing. This includes testing for learning disabilities, including dyslexia or reading learning disability, dyscalculia or math learning disability, dysgraphia or written language/handwriting disability. We are happy to provide this service for your child; however, there is a fee for this in addition to your insurance company's co-pay and/or co-insurance; this fee will be discussed with you in advance.

Insurance companies also will not cover school meetings, such as those related to ARDs, 504s, or Special Education. Once again we are happy to provide this service for your child, however there is a fee of $150 per hour for such meetings. This will be discussed with you in advance.

If we are out-of-network for your insurance company, we will let you know the fee for the requested service, which is due at the time of service. We will file your claim if you request that we do so, requesting that any payment go directly to you. It will be up to you to provide any documentation your insurance company may request to consider payment of the claim.

Whether the services we provide are covered by your insurance company depends on the provisions of your plan. Please be aware that there is no guarantee that your insurance company will cover the service(s), even if they initially say they will do so. It has been our experience that insurance companies sometimes deny or reduce coverage based on the terms of your particular plan, the diagnosis, and/or their beliefs about whether the service is medically necessary. Their beliefs may differ from your beliefs, ours, and/or those of the referring physician.

Insurance Company: _____

I have read the above information and agree to proceed with the requested services. I also understand that if my child does not arrive for a scheduled appointment, there will be a $35 no show/late cancellation fee, as this time has been reserved specifically for my child. I understand that this fee will not be covered by my insurance company.

_____ _____

Signature of Parent (or Guardian) Date

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This form, when completed and signed by you, authorizes clinicians and staff at Neuropsychology Consultants to release protected information from your child's clinical record to the person(s) or entity(s) you designate and to obtain protected information from the person(s) or entity(s) you designate.

Child's Name: _____

Date of Birth: _____

I authorize the staff of Neuropsychology Consultants to release records or information, OR to obtain records or information regarding the above named person. These records may include any medical records, academic records, psychological or neuropsychological evaluations, treatment notes, diagnosis, recommendations, or any other information that is related to my child's care.

I authorize my records and information to be released to or obtained from the following individuals or entities:

Name: _____ Phone: _____

Address: _____ Fax: _____

Name: _____ Phone: _____

Address: _____ Fax: _____

Name: _____ Phone: _____

Address: _____ Fax: _____

Name: _____ Phone: _____

Address: _____ Fax: _____

Name: _____ Phone: _____

Address: _____ Fax: _____

This authorization shall remain in effect for one year from the date of signing or until _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____

Printed Name of Parent (or Guardian)

_____ _____

Signature of Parent (or Guardian) Date