CONSENT FOR SERVICES, POLICIES,

AND FEE AGREEMENT

NeuroBehavioral Concepts | llc
Tax ID 26.2350260
NPI 1851574404
www.neurobx.com
503.803.9361

Responsible Party's Name:_____

Client Name: _____ DOB: _____

Address:_____

_____

Welcome to Neurobehavioral Concepts or as we like to call it, NBx. We are pleased you have chosen us for services and will do everything possible to help make your experience positive and helpful. Please read the information below, sign and date the form.

## GENERAL FINANCIAL POLICES

NBx does not contract with any private health plans. This means financial agreements are established directly between NBx and clients/families, and not between NBx and any privately-owned third-party companies or entities. The client therefore assumes financial responsibility for professional fees accrued over the course of psychological services.

## OFFICE HOURS

Our office hours are from 7:00 a.m. to 5:00 p.m. Monday through Friday. If you leave a voice message and we haven't gotten back to you within 24 hours, please assume we have been unable to connect with you and call again.

## COMMUNICATION VIA VOICE MAIL/EMAIL

Voice mail and email should be utilized for setting/changing appointment times. Email may be used as a form of data collection, in consultation with your therapist, if you wish but we are unable to respond to issues of a therapy nature via email or voice mail.

## CRISIS SITUATIONS

NBx is not a crisis facility. If a life threatening or other crisis situation arises, please take the following steps: (1) call 911, (2) call your local mental health crisis line, or go to the nearest emergency room, (3) call your counselor to make them aware of the situation.

## SCHEDULING APPOINTMENTS/CANCELLATION/NO SHOW POLICY

Scheduling appointments is your responsibility and is done online at www.NeuroBx.com/calendar. For the consideration of your therapist and other clients, you are expected to keep scheduled appointments or cancel at least 24 hours in advance. If you do not attend nor cancel an appointment with your therapist at least 24 hours ahead of the appointed time, you will be charged for the missed session,

which is not covered by any insurance. Allowances are made for emergencies. 1ST no show or less than 24 hour cancellation: $75.00, 2nd no show or less than 24 hour cancellation: Full fee.

## COUNSELING/THERAPY SESSIONS

Therapy sessions usually last 45 to 50 minutes. Their frequency will be determined between you and your therapist according to your need. Group therapy sessions are usually 60 minutes to two hours in length depending on the type of group and generally meet for a specified period of time. Parents who bring their children to NBX are responsible for their supervision at all times in the waiting room and/or the property at large.

## NOTICE OF CONFIDENTIALITY AND LIMITATIONS

Federal and state laws and regulations protect the confidentiality of mental health records maintained by us. Violation of such is a crime. No information is released to any source outside the agency without your written permission or a court order, a medical emergency, or audit. Crimes committed against the NBX staff, property, or threats of crimes are not protected by confidentiality laws. Suspected child/elder abuse or neglect is not protected and must be reported to proper authorities. If you have questions or concerns about confidentiality, please discuss these with your therapist. You will also be provided with a Notice of Privacy Practices that covers how your health information is used and disclosed.

**PARENTS OF MINOR CLIENTS:** It is very important that children have a sense of privacy in their counseling in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgment of what is in the child's best interest from a therapeutic standpoint. Because the therapeutic relationship is vital to change and support, we actively discourage parents from including the counselor in any court proceedings involving the children. At this time we do not provide child custody evaluations.

**CONFIDENTIALITY FOR COUPLES/FAMILIES/GROUPS:** Discuss with your counselor how you will handle spouse phone calls, scheduling, or individual sessions and the limits of confidentiality where couples, families and groups are involved.

## CANCELLATION/NO SHOW POLICY

Insurance will not reimburse for missed appointments, and these charges are your responsibility.

## FEES AND PAYMENT

All co-pays are due at the time of service. We accept cash or check made payable to NBx. We also accept Credit Card payment with a 5.0% fee.

- Our current fee per session is $400 for the first diagnostic session, $150 for sessions thereafter.
- The fee for telemedicine (sessions via video conferencing devices) are $225.00 per session.
- Expert/ Witness Testimony is charged at $400.00/hr. This includes preparing for such legal action, including, but not necessarily limited to, traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of my involvement in such legal action. This fee is due one week prior to the court proceeding. Additional fees will incur for each additional hour the therapist is required t o be retained at court.

If a balance is owed and remains unpaid after the due date of the invoice, you will be asked to postpone further sessions until your account is brought to a "zero" balance. If any or all outstanding balances are not paid, NBx reserves the right to release a client's name and address to a collection agency. Also, a

monthly interest fee of 10% will be charged for these balances until they are paid in full. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds.

INSURANCE COVERAGE FOR PSYCHOTHERAPEUTIC SERVICES

Although NBx has opted to be an out-of-network provider with private insurance plans, many health plans include out-of-network benefits. If available, such benefits can provide families with some level of financial reimbursement, and many clients therefore opt to utilize these benefits to defray part of the costs for psychological services. Please note that private health plans vary widely in their reimbursement rates and payment practices. For example, most insurers and health plans categorize struggles with academic issues as educational in nature, rather than as health-related. They therefore may consider them "not medically necessary," and might not provide reimbursement for testing focused on such matters.

Additionally, many insurance companies will reimburse for therapies if "coded" in particular ways. Please note that we code services based on what actually occurs in a session. We produce a high standard of professional services and our invoices reflect those services, we feel that it is unethical to change codes so ensure reimbursement. In that light, we encourage families to retain the invoices sent, as we are not responsible to make copies of invoices after they have been received.

## POLICIES AND FEE AGGREMENT

I have read and understand this agreement and have had the opportunity to ask questions about it. I agree to pay at time of service the amount listed above for therapy sessions, in addition to other charges in connection with my treatment, as listed above. If my financial circumstances change, I will promptly advise the Clinical Director at (503) 803-9361.

X_____ Date: _____
Client Signature (Parent/Guardian if minor)

X_____ Date: _____
Client Signature (2nd Parent/Guardian if minor)

## Electronic Communication Consent

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are non-emergent, non- urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider/team relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

### General Considerations

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services, such as AOL, Yahoo and Hot Mail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your email address will not be used for external marketing purposes.
- You may receive a group emailing from the practice (in the event of the clinician being ill or some other scheduling issue), however, the recipients email addresses will be hidden.

### Healthcare Team Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your email messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your email.
- Every attempt will be made to respond to your email message within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

### Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent or time sensitive situations, you should contact the practice by phone.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please include your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return email to the sender.

## Electronic Communication Consent

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare team.

I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

I have been given the opportunity to discuss electronic communication with a representative of NBx and have had all my questions answered.

In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I herby consent to electronic communication via non-secure email services.

I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the address below, but if I do, the revocation will not have an affect on actions my healthcare provider or team has already taken in reliance on my consent.

I agree and release my provider and practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

PATIENT

_____ Patient Authorized Email Address (please print)

_____ Patient Name (Print)

_____ Patient Signature Date

PARTNER/ PARENT (if applicable)

_____ Patient Authorized Email Address (please print)

_____ Patient Name (Print)

_____ Patient Signature Date

# PATIENT REGISTRATION FORM

neurobehavioral CONCEPTS
children · teens · family
counseling · clinical services · consultation
503 803 9361

## GENERAL INFORMATION (REQUIRED)

Patient's Name: _____ Birth Date: _____
(Last) (First) (Middle Initial)

Social Security Number: _____ Male _____ Female _____

Home Address: _____
(Street / RR Box #) (City/State) (Zip)

Preferred Contact By: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Email Address: _____

Home Phone: _____ Cell Phone: _____
(Area Code) (Area Code)

Work Phone: _____ Employer: _____
(Area Code)

Family Physician: _____ Phone: _____
(Area Code)

Pharmacy: _____ Phone: _____
(Area Code)

I give my consent to NBX's providers and/or staff to contact the following person in the event of an emergency:

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____
(Area Code)

# PATIENT REGISTRATION FORM

## CONSENT TO TREAT

I request and authorize NeuroBehavioral Concepts | llc (hereinafter collectively referred to as "NBX") and their respective agents and employees who may attend to me during my treatment to perform routine tests and procedures and to provide certain services as prescribed for my health and well-being in accordance with applicable laws and regulations. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by NBX, nor have I relied upon any such representations, warranties, or guarantees.

_____ _____

Patient Signature or Legal Guardian Signature if patient is a minor Date

If signed by Legal Guardian, state relationship to patient: _____

## ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of the NBX Patient Admission Packet, which includes but is not limited to the Notice of Privacy Practices ("Notice"). I understand that I may obtain a written copy of this Notice at any time upon request or via the website at NeuroBx.com

_____ _____

Patient Signature or Legal Guardian Signature if patient is a minor Date

## GENERAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Today's Date: _____ Who referred you here? _____

How did you hear about NeuroBehavioral Concepts | llc :

- Family Dr. (Dr.'s name: _____)
- Therapist (Therapist's name: _____)
- School (School name: _____)
- Family member
- Friend / Coworker
- NBX Website
- Other (_____)

## PRESENTING PROBLEM & HISTORY OF TREATMENT

1. In the space below, please state why you are coming in today:

2. When did this become a problem?

3. Have you had any type of treatment for this problem? If so please describe:

## HISTORY OF EMOTIONAL OR BEHAVIORAL PROBLEMS

| 4. For each item below, please indicate if you feel this has been a problem for you either currently, in the past, or both. | | Current | Past |
|---|---|---|---|
| | Depression | | |
| | Anxiety (general) | | |
| | Anxiety around people | | |
| | Attention | | |
| | Concentration | | |
| | Memory | | |
| | Anger | | |
| | Suicidal Thoughts | | |
| | Cutting or other self-harming behavior | | |
| | Eating Problems | | |
| | Body image concerns | | |
| | Aggressive behavior | | |
| | Unstable Mood | | |
| | Unable to think clearly | | |
| | Seeing/hearing things that are not there | | |
| | Sex | | |
| | Sleep | | |

5. Please give any information you wish about the issues referenced on the previous page:

6. In the box below, please indicate any medications that you currently take:

| Medicine | Dose | Reason | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

7. Please list any other psychiatric medicines you have taken in the past:

| Medicine | Dose | Reason | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

8. In the box below, please give any other history of previous counseling/psychotherapy:

| Type of Therapy | Length of Treatment | Reason | Outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

9. Please indicate below any psychiatric hospitalizations.

## SOCIAL HISTORY

10. Religious/spiritual orientation:

11. Cultural/ethnic identification:

12. Sexual orientation:

13. What do you consider to be your best qualities?

## EDUCATIONAL HISTORY

14. What is the highest grade or level of training you have achieved?

15. For each time period listed, please say a little about how you did in school (grades, attitude to school, friend/peer relationships, activities, problems, accomplishments, etc.).

Elementary:



Middle School/Junior High:

High School:

College:

## SUBSTANCE USE

16. Please describe below your use of any of the following substances:

| | Present Use | Past Use |
|---|---|---|
| Alcohol | | |
| Tobacco | | |
| Marijuana | | |
| Cocaine | | |
| Hallucinogens | | |
| Other | | |

## FAMILY INFORMATION

17. To the best of your knowledge, has any biological relative, or anyone you lived with, had a problem with the following:

| | Please Describe |
|---|---|
| Depression | |
| Anxiety | |
| Suicide | |
| Bipolar Disorder | |
| Schizophrenia | |

## ADULT INTAKE QUESTIONNAIRE

| | |
|---|---|
| Eating Disorder | |
| Attention | |
| Learning Problems | |
| Anger | |
| Aggression | |
| Substance Abuse | |
| Illegal Behavior | |
| Other: | |

# HIPAA PRIVACY AUTHORIZATION FORM

*Authorization for Use or Disclosure of Protected Health Information*
*(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)*

## AUTHORIZATION

I authorize NeuroBehavioral Concepts | llc (Healthcare Provider) to use and disclose the protected health information described below to _____(individual seeking the information).

## EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

a. ☐ _____to _____.
**OR**
b. ☐ all past, present, and future periods.

## EXTENT OF AUTHORIZATION

a. ☐ I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
**OR**
b. ☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including
- ☐ HIV and AIDS) Alcohol/drug abuse
- ☐ treatment
- Other (please specify): _____

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

2. This authorization shall be in force and effect until _____(date or event), at which time this authorization expires.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest my claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

| Signature of Patient or Personal Representative | Printed Name | Date |
|---|---|---|