PATIENT REGISTRATION

Patient's Name: First _____ M.I._____ Last_____

Street/Billing Address: _____

City: _____ State: _____ Zip: _____-_____

Main Phone: _____Alternate Phone: _____

Birth Date: _____ Gender: M / F SSN: _____

Email Address: _____

Marital Status: Single / Married / Divorced / Widowed

Responsible Party if Under Age of 18: _____ Relationship to Patient: _____

Referring Physician: _____ Primary Care Physician: _____

Employer's Name: _____ Emergency Contact: _____

Address: _____

RESPONSIBLE PARTY / INSURANCE GUARANTOR

Name: _____ M.I. _____ Last: _____

Address: _____

Main Phone: _____ Email: _____

Date of Birth: _____ Relationship to Patient: _____SSN: _____

Main Phone: _____ Alternative Phone: _____

Employer: _____Telephone: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical benefits, to include all major benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Arias Neuropsychology & Behavioral Medicine, P.C. This assignment will remain in effect until revoked by mc in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and costs. I hereby authorize Arias Neuropsychology and Behavioral Medicine, PC, to release to the insurance companies above or to any other payer (i.e. Attorney, Workman's Compensation Company, etc.), to myself, to my PCP, and to my referring physician, any information necessary for treatment or payment. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

Signature: _____Date: _____

Responsible Party: _____Date: _____

ARIAS NEUROPSYCHOLOGY AND BEHAVIORAL MEDICINE • 1500 S. 48th Street, Suite 510 • Lincoln, NE 68506 • 402-323-8890 • 402-323-8893 Fax

AUTHORIZATION TO SEND/RECEIVE PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Former Name(s)		
Current Address	City	State	Zip
Telephone	D.O.B. (mm/dd/yyyy)	Social Security #	

If you, the patient, would like a copy of your report please check this box ☐

I am requesting my PHI/records to be: ☐**RELEASED TO** ☐**OBTAINED FROM**

Name/agency/clinic:	
Address	
City, State, Zip	
Telephone	FAX

Office use only: □Faxed □Mailed

Name/agency/clinic:	
Address	
City, State, Zip	
Telephone	FAX

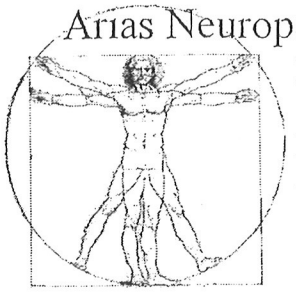
Office use only: □Faxed □Mailed

☐**Evaluation/Test results** ☐**Other (specify):**_____

I hereby authorize Arias Neuropsychology and Behavioral Medicine, PC the use or disclose of my personal Health Information (PHI) as described above. I understand that this release becomes effective on the day I sign it and is valid for a period of ***12 months*** *from the date signed. It may be revoked at any time, except to the extent information has already been released, by notifying Arias Neuropsychology and Behavioral Medicine, PC in writing, of my intention to revoke this release. I voluntarily sign this authorization and understand that my health care will not be affected if I do not sign the release. Once disclosed to an outside party, my PHI cannot be guaranteed protected under HIPPA Privacy Laws.*

Patient/Guardian Signature	Date
Witness Signature	Date

Arias Neuropsychology and Behavioral Medicine, PC
Robert G. Arias, Ph.D.
1500 S. 48th Street, Suite 510
Lincoln, NE 68506
402-323-8890 / 402-323-8893 fax



CONSENT AND OFFICE POLICIES

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: By signing this form, you are granting consent to Arias Neuropsychology and Behavioral Medicine, PC to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you read it in full. Our Notice of Privacy Practices is subject to change. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.
I acknowledge that I have been offered a copy of Arias Neuropsychology & Behavioral Medicine, P.C. Notice of Privacy Practice Policy, which describes how my health insurance information may be used or disclosed.

NO SHOW AND CANCELLATION POLICY: If you arrive more than ten minutes past your scheduled appointment, you may be considered a no show. We ask for cancellations to occur no less than 24 business hours prior to your appointment, unless there is an unforeseen emergency. Three late cancellations or no shows will result in a release from the clinic and will require a new referral. This policy also applies for any other appointments in this clinic, with any provider. Another outpatient doctor's appointment, lack of transportation, or work conflict is *not* considered an emergency. If an emergency does occur that necessitates canceling the appointment, it is your responsibility to call as soon as possible to let us know. This will give us an opportunity to fill the appointment. **If you no-show for an appointment or cancel less than 24 business hours before an appointment *without* an unforeseen emergency, you will be charged $50 for *each* hour that was scheduled for you.**

LIMITS OF CONFIDENTIALITY AND CONSENT TO TREAT: Information obtained during assessments and psychotherapy is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults, and c) issuance of a subpoena from a court of law. A report is also provided to the referral source, typically for the purpose of treatment, unless you specifically indicate, in writing, you do not wish this to occur.
I agree and consent to participate in behavioral health care services offered and provided at/by Arias Neuropsychology and Behavioral Medicine, PC, to include all its behavioral health care providers. I understand that I am consenting and agreeing only to those services within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Responsible Party Signature Date

Psychological/Neuropsychological Assessment Informed Consent

(Please Read the Entire Consent Form)

Nature and Purpose of Assessment: You have been referred for a psychological or neuropsychological assessment. Such an assessment may point to changes in some aspect of your functioning (emotionally, cognitively, and/or behaviorally) and suggest possible methods of rehabilitation. In addition to an interview, where I 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, listening to recorded tapes, viewing printed material, and manipulating objects. There may also be other goals specific for your situation.

Foreseeable Risks, Discomforts, and Benefits: For some individuals, assessments can cause fatigue, frustration, and anxiousness. Please mention any concerns you may have at any point in the evaluation. It is within your right to terminate the evaluation at any point.

Time Commitment: Assessments such as these may last from one to several hours depending on the specific case. Additional hours are also taken to interpret the data and prepare a report. Fees are generally covered by insurance at contracted rates, which vary depending on the insurance. However, patients are ultimately responsible for any and all fees for the assessment. This includes your insurance deductible. If payment will be made from an alternative source (e.g., an attorney or private pay), please discuss this with me. Given that we are committing a large portion of time to you for this evaluation or treatment, we ask for cancellations to occur no less than 24 business hours prior to your appointment, unless there is an unforeseen emergency. If an emergency does occur that necessitates canceling the appointment, it is your responsibility to call as soon as possible to let us know. This will give us an opportunity to fill the appointment. For child or adult neuropsychological evaluations and chronic pain evaluations, we typically schedule *five* hours.

No Show and Late Cancelations: If you arrive more than ten minutes past your scheduled appointment, you may be considered a no show. We ask for cancellations to occur no less than 24 business hours prior to your appointment, unless there is an unforeseen emergency. Three late cancellations or no shows will result in a release from the clinic and will require a new referral. This policy also applies for any other appointments in this clinic, with any provider. Another outpatient doctor's appointment, lack of transportation, or work conflict is *not* considered an emergency. If an emergency does occur that necessitates canceling the appointment, it is your responsibility to call as soon as possible to let us know. This will give us an opportunity to fill the appointment. **If you no-show for an appointment or cancel less than 24 business hours before an appointment *without* an unforeseen emergency, you will be charged $50 for *each* hour that was scheduled for you.**

Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults, and c) issuance of a subpoena from a court of law. A report is also provided to the referral source, typically for the purpose of treatment, unless you specifically indicate, in writing, you do not wish this to occur.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing. I wish to proceed with this evaluation.

_____

Patient Signature Date

_____

Parent/Guardian or Authorized Surrogate (if applicable) Date

_____

Witness Signature **(OFFICE PERSONNEL WILL SIGN WHEN RECEIVED)** Date