



PATIENT REGISTRATION

Patient's Name: _____ Maiden Name: _____

Date of birth: ____ / ____ / ____ Age: ____ Gender: _____ Marital Status: _____

Phone: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Employment Information

Employer Name: _____

Address: _____

Phone: _____

May We Contact You at Work?

- Yes
 No

Account Guarantor

Relationship to patient (if "self," you may skip the rest of this section): Self Other (please describe):

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____ Phone: _____

For child and adolescent patients, please complete the following:

Mother
Name: _____

Father
Name: _____

Phone: _____

Phone: _____

Referred to SC Neuro by: _____

Some insurance carriers require the following information for payment processing. Please select ONE choice from each of the categories below:

Ethnicity:

- Hispanic or Latino Not Hispanic or Latino Declined

Race:

- American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander
 White Other Declined

Relationship To Insured:

- Spouse Child Significant Other Self
 Mother Father Life Partner Grandfather or Grandmother
 Grandson or Granddaughter Nephew or Niece Adopted Child Foster Child
 Stepson or Stepdaughter Handicapped or Dependent Dependent or a Minor of Dependent Employee
 Organ Donor Cadaver Donor Emancipated Minor Injured Plaintiff
 Child Where Insured Has No Financial Responsibility Ward Other Unknown

OFFICE POLICY

At SC Neuro, we love what we do, and our goal is to deliver the most efficient, complete care that is available, anywhere. We will discuss assessment and possible treatment options during today's appointment, as well as any and all associated costs and fees. This office policy details some of these issues. Please ask about anything that is unclear.

Insurance, Fees, and Payments

We will pre-certify your benefits and estimate costs in advance of your appointment(s). Please note that this is an estimate, and not a guarantee. We will also submit your insurance claims for each appointment. We will not, however, negotiate on your behalf after your insurance carrier issues payment.

Please be prepared to pay the estimated charges for your appointment(s). Any payment for your care, including co-pays, deductibles, and non-covered services, is *due on the day of your appointment*. If your insurance company does not pay you are responsible for payment in full. Payments can be made with cash, personal check, and debit and credit cards. Please note that there will be a \$20.00 service charge on all returned checks. Checks should be written to W. Howard Buddin Jr., Ph.D. We encourage you to contact your insurance company to verify your coverage and determine the limits of your coverage.

We charge \$100 for missed interview or feedback appointments, and \$200 for missed testing appointments. These charges are neither billed to, nor covered by, your insurance carrier. If you elected to have an interview and testing appointments on the same date, we charge a \$200 deposit that will be applied to any patient financial responsibility. This deposit is non-refundable if you cancel or reschedule with fewer than 24 hours advance notice. Please do not hesitate to ask if you have further questions about how this deposit is handled.

All evaluations requiring testing have an additional, one-time, non-refundable \$50 fee that covers the costs associated with the technology and instruments used during the course of the evaluation. This fee is not billable to/covered by your insurance carrier, is assessed separately, and is due on the date of your assessment (usually the appointment following the intake interview). Checks should be written to SC Neuro.

Scheduling & Appointments

Reserving time for your particular needs is our priority. Please be aware that your appointments will begin and end according to the scheduled time. We cannot add time if you arrive late. In the event of a late arrival, you will be charged for the full clinical hour. Please give us at least 24 hours' notice if you must cancel or change an appointment. This courtesy makes it possible for us to give your time to someone else in need. Repeated cancellations or missed appointments might result in loss of future appointment privileges. Lastly, we will not schedule you for another appointment if you twice cancel, reschedule, or miss your assessment/testing appointment.

For Divorced Parents of Children who are Patients

The custodial parent is always legally responsible for the entire case fee without regard to divorce decree or any separate agreement that might exist. In joint custody, one parent must be accountable for the fee. There is no situation where splitting the case fee or making two financial arrangements for one case fee is acceptable or appropriate. The custodial parent must always provide documentation to the fact that they are (a) the custodial parent and (b) legally responsible for medical, mental health, and/or psychiatric healthcare decision-making. If you do not have this documentation with you, we will not see your child and we will have to reschedule the appointment.

Forensic/Legal Involvement

Please let us know, as early as possible, if you are involved in any sort of litigation, as it can have a significant impact on many aspects of the evaluation process, including cancellation of future appointments. Dr. Buddin works only as an expert witness in forensic/medicolegal cases, not as a fact witness. Please ask if you are not sure about what this means.

Assignment of Benefits/Financial Responsibility

I assign all insurance benefits, if any, otherwise payable to W. Howard Buddin Jr., Ph.D./Andrea Sartori, Ph.D./South Carolina Neuropsychology, LLC (SC Neuro, LLC) for services rendered. I understand that I am ultimately responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I have read the information stated above and I am in agreement with the policies and procedures as presented.

Confidentiality & Office Procedures

Information regarding treatment will not be released unless there is written consent from the patient or the patient's legal guardian or caregiver. Information can be released *without consent or assent* (assent is consent that is spoken) in the following cases: indication that immediate danger to self or others exists; a court order that directs the release of information; disclosure of sexual abuse, physical abuse and/or neglect of a child under the age of 18. If this evaluation is being conducted as part of legal proceedings, confidentiality may not apply, as information will be released to your attorney and may be discussed as part of a deposition and/or courtroom proceedings.

Communication Between Patient/Caregiver and Our Office

You have the right to request and have our office communicate with you by alternative means. For example, we can accommodate your request to receive appointment reminders by text or phone or send a link to your evaluation report and billing statements by e-mail. Email is an *unencrypted* form of communication. This means that SC Neuro, LLC/W. Howard Buddin Jr., Ph.D./Andrea Sartori, Ph.D. have implemented policies and procedures to restrict access to, protect the integrity of, and guard against unauthorized access to electronic Personal Health Information (e-PHI). If you would like, we can send you a link to download an encrypted version of your report and other medical records containing your PHI.

Please choose one of the following:

I understand the risks of using email to send and/or receive my PHI and do hereby give SC Neuro, LLC/W. Howard Buddin Jr., Ph.D./Andrea Sartori, Ph.D. permission to communicate with me via email.

NOTE: Please *do not* give an email address associated with your employer/job/school. Please give only a personal email address (such as @gmail, @hotmail, @yahoo, etc.)

Email address: _____

Please use the United States Postal Service to send my report and/or anything with my PHI.

ACKNOWLEDGMENT, AGREEMENT, AND CONSENT

I agree to have Dr. Buddin/Dr. Sartori perform neuropsychological and/or psychological testing, psychotherapy, and/or related mental health treatments, but I may at any time decline specific recommendations. I also agree to allow Dr. Buddin/Dr. Sartori to consult with other professionals deemed appropriate and necessary in providing quality care. Patients can file inquiries with the South Carolina Board of Examiners in Psychology. The Board of Examiners in Psychology offices may be reached at:

SC Board of Examiners in Psychology
P.O. Box 11329
Columbia, SC 29211-1329

I assign all insurance benefits, if any, otherwise payable to W. Howard Buddin Jr., Ph.D./Andrea Sartori, Ph.D./South Carolina Neuropsychology, LLC (SC Neuro) for services rendered. I understand that I am ultimately responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize Dr. Buddin/Dr. Sartori to release relevant/necessary information to my insurance company and the professional who referred me (or my child). This information is protected under the HIPPA Privacy Act. I have read the information stated above and I am in agreement with the policies and procedures as presented.

I acknowledge that I have received the HIPAA notice of Privacy Practices and Patient Services Agreement from W. Howard Buddin Jr., Ph.D./Andrea Sartori, Ph.D./South Carolina Neuropsychology, LLC (SC Neuro).

I have read all information above, and I am in agreement with the policies and procedures as presented.

Signature (Patient/Guarantor or Parent/Guarantor)

Relationship to patient if other than self

Print Patient's name

Date

Assent granted on:

Date

Time

PLEASE KEEP THE FOLLOWING PAGES FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. *Please review it carefully.*

YOUR RIGHTS

This section explains your rights and some of our responsibilities to help you.

You have the right to:

Obtain an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request; however, if we refuse your request, we will explain why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say “yes” unless a law requires us to share that information

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or by visiting:
- <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>
- We will *not* retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, please talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

Please note: If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes

- Sale of your information
- Most sharing of psychotherapy notes

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.

To evaluate and/or treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To run our practice

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

We may also use your information in other ways that do not require your consent.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html>

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date of this notice: September 25, 2019