Neuro & Brain
Performance Centers, LLC

Authorization to Release Medical Records

(Please provide complete and accurate information when submitting this form)

Patient's Name _____ Date of Birth _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Social Security Number _____

I, _____, authorize the release of my health care information concerning (please check off at least one of the following):

1) _____ All Physical/Occupational Therapy Records

2) _____ Treatment of (please identify condition) _____

3) _____ Treatment received on the following dates from: _____ to _____

4) _____ Other (please describe) _____

I, _____, authorize the release of my health care information to **Neuro & Brain Performance Centers, LLC:**

◯ **Mesa Office location: 6840 E. Brown Road, Suite 104, Mesa, AZ 85207**
Phone: 480-719-8080 FAX 888-375-1033

Patient Signature: _____ Date: _____

If patient is minor under 18,

Guardian Signature _____ Date: _____

Guardian Name (Please print) _____

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Additional Patient Demographic Data

Social Security No: _____ ◯ Married ◯ Divorced ◯ Widowed ◯ Single

Email address: (For apt. reminders) _____

Cellphone: _____Other phone: _____

Occupation: _____Employer: _____

Work Status: ◯ Currently Employed ◯ Unemployed ◯ Retired ◯ Disabled

If patient is incapacitated or is a Minor: Name of Parent/Guardian/ or person holding Power of Attorney:

_____

Signature of responsible party: _____

Emergency Contact _____Phone #: _____

Referral Information (How did you hear about us)

◯ Referring Doctor _____ Phone _____

◯ Friend (Name) _____ ◯ Website ◯ Facebook

◯ Article in _____ ◯ Walk-in

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Insurance Information

We need a copy of your insurance card(s)

Primary Insurance Name: _____ Number: _____ Group No._____

Policyholder Name: _____ DOB _____

Policyholder SSN: _____ Policyholder's Employer_____

Employer Phone: _____ Claim Number: _____

Policyholder's relationship to patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other _____

Patient Name: _____ ID _____ DOB_____

Co-pay for office visits is $ _____ Deductible is $ _____ Coinsurance % is _____

Any maximums? _____

Secondary Ins. Name: _____ Number: _____ Group No._____

◯ Self-Pay (Cash, Credit Card, Check)

◯ Workers Compensation (All information under "My Condition must be provided.)

◯ I have an attorney. His/Her name and contact information is as follows:

_____

_____

_____

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My Condition

My injury/aliment is related to – ◯ Personal injury. Date of incident: ____/_____/_____

◯ Auto accident. Date of incident: ____/_____/_____ Insurance Company _____

Insurance Adjuster's Name: _____ Phone _____

◯ Work injury Date of incident: ____/_____/_____

Your company's Worker Compensation carrier: _____

Your company's WC coordinator's name: _____ phone _____

◯ No injury. Date symptoms began: ____/_____/_____. I think it was caused by _____

_____

Related to this condition I have already had –

◯ Surgery: Type_____Date_____

◯ Physical/Occupational Therapy: Where_____ Date_____

◯ Home Healthcare. Are you still receiving it? ◯ Yes ◯ No

The STarT Back Musculoskeletal Screening Tool

Thinking about the last 2 weeks, tick you response to the following questions:

1)	My pain has spread at some time in the past 2 weeks	◯ Agree	◯ Disagree
2)	In addition to my main pain, I have had pain elsewhere in the past 2 weeks.	◯ Agree	◯ Disagree
3)	In the past 2 weeks I have only walked short distances because of my pain.	◯ Agree	◯ Disagree
4)	In the past 2 weeks I have dressed more slowly than usual because of my pain.	◯ Agree	◯ Disagree
5)	It's really not safe for a person with a condition like mine to be physically active.	◯ Agree	◯ Disagree
6)	Worrying thoughts have been going through my mind a lot of the time in the past 2 weeks.	◯ Agree	◯ Disagree
7)	I feel that my pain is terrible and that it's never going to get any better	◯ Agree	◯ Disagree
8)	In general in the last 2 weeks, I have not enjoyed all the things I used to enjoy	◯ Agree	◯ Disagree

9) Overall, how bothersome has your pain been in the past 2 weeks:

◯ Not all all ◯ Slightly ◯ Moderately ◯ Very Much ◯ Extremely

Pain level at rest: (Circle one) No pain 1 2 3 4 5 6 7 8 9 10

Pain level when moving: (Circle one) No pain 1 2 3 4 5 6 7 8 9 10

What are your goals for this therapy treatment? _____

_____

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Medical History

Medications I am taking or have taken in the past 3 months – including any anti-inflammatory, muscle relaxers, or pain medications.

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency
(1)			(5)		
(2)			(6)		
(3)			(7)		
(4)			(8)		

Please circle all that apply. If yes, please give a brief explanation and an approximate date.

Allergies Yes No _____
Asthma Yes No _____
Bowel/Bladder Problems Yes No _____
Bronchitis/Emphysema Yes No _____
Cancer Yes No _____
Diabetes Yes No _____
Headaches Yes No _____
Heart Attack Yes No _____
Heart Disease Yes No _____
Hernia Yes No _____
High Blood Pressure Yes No _____
Kidney Problems Yes No _____
Metal Implants Yes No _____
Nervous Disorders Yes No _____
Osteoporosis Yes No _____
Pacemaker Yes No _____
Previous Surgery Yes No _____
Seizures Yes No _____
Sensitivity to Cold Yes No _____
Sensitivity to Heat Yes No _____
Stroke or TIA Yes No _____
Do you smoke Yes No _____

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Consent for Physical/Occupational Therapy Treatment/ QEEG (Quantitative Electroencephalogram)/ Neurofeedback Therapy

As a patient of Neuro & Brain Performance Centers, LLC (NBPC) I understand & agree to the following:

1) **Cooperation with treatment –** In order for physical/occupational therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I will cooperate with and perform the home physical therapy program made available to me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.
2) **No warranty –** I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my therapist will outline and discuss goals of physical/occupational therapy treatments for my condition and will discuss treatment options with me before I consent to treatment.
3) **Informed consent for treatment –** The term "informed consent" means that the potential risks, benefits, and alternatives of physical/occupational therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition, including QEEG (Quantitative Electroencephalogram) brain imaging and Neurofeedback therapy if it is applicable.
4) **Potential risks –** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical/occupational therapist.
5) **Potential benefits –** I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.
6) **Alternatives -** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physical/occupational therapist, as well as my physician or primary care provider
7) **Educational use –** I give permission for NBPC and its affiliates to use my brain QEEG results and pictures for educational purposes, including seminars, speaking engagements, NBPC website and social media networking pages, etc. My results and pictures will not identify me by name, birthdate, etc. I also understand that I can rescind this consent at any time by notifying NBPC in writing.

I have read the above information and I consent to physical and occupational evaluation and treatment, including QEEG (Quantitative Electroencephalogram) analysis and Neurofeedback therapy.

_____

Patient Name (Print) Date Signature

_____

Patient's Parent/Guardian Name (Print) Date Signature

Neuro & Brain
Performance Centers, LLC

Dear Friends and Patients,

Our practice exists to take excellent care of our patients and our employees. We are 100% committed to accomplishing that two-fold mission. In order to deliver the high-quality, caring treatment that all our patients deserve, we must collect fair and adequate compensation for the services that we provide. Otherwise, we cannot take care of our patients or our employees.

Our costs continually increase due to ever-changing and expanding government regulations and insurance company policies. We have invested thousands of dollars (equipment, software, training, etc.) to enable our front office and billing personnel to gather and submit the documentation that insurance companies require in order to pay claims. But unfortunately many insurance companies deliberately deny legitimate insurance claims as a way to avoid or at least delay paying benefits.

For these reasons we have been forced to adopt the following policies that our front office personnel don't have the authority to change:

Patients without insurance will pay the "cash pay" price before receiving treatment.

Special Note to Patients with Insurance – we have found that patients who become actively involved and communicate with their insurance company often are able to get the insurance company to pay claims that they initially denied.

Financial Responsibility Agreement

- I understand and agree that I am totally responsible and liable for payment of all the charges assessed for professional services that are rendered. I will pay these charges upon demand.
- Neuro & Brain Performance Centers (NBPC) participates with a number of health plans and if your plan is one of these, we will file a claim with your provider for covered services. It is your responsibility to provide Neuro & Brain Performance Centers (NBPC) correct insurance billing information at the time of your first visit and to notify NBPC of any subsequent changes to that information. If correct insurance information is not given and/or payments are denied by the insurance company for any reason, you are responsible for payment in full.
- Some insurance plans require a co-payment for each visit and NPBC is under contractual obligation to collect those co-pays from you. You are also responsible to pay for any and all supplies, such as braces and exercise equipment, and non-covered services which are provided to you and are not covered by your particular insurance plan. I understand that I am financially responsible for insurance deductibles, co-payments, and for supplies and services that are not covered by my insurance.
- We have no control over the benefits you have under these plans. It is your responsibility to contact your plan representatives to verify your benefits, co-payments, deductibles, etc. Be sure to keep all correspondence from your insurance company. These plans often require you to pay a deductible before your insurance company begins to pay for your care. Deductibles usually start over every January.

- In the event that my insurance forwards payment directly to me instead of Neuro & Brain Performance Centers (NBPC) or its assignees, I will immediately deliver such payment directly to Neuro & Brain Performance Centers.
- I understand and agree that if it becomes necessary to commence legal action for the collection of any unpaid charges on my account, I will be responsible for any collection or court fees in addition to the outstanding balance of my account.
- I understand that there will be a 1.5% late charge per month on any remaining unpaid copay or deductible balance on my account that is not paid within 30 days of when my insurance company pays or settles the claim.
- A $35 fee will be charged for any returned checks. Post-dated checks are not accepted.
- The information that we relay to you regarding your insurance is only a quote of what your insurance company told us when we called to verify your benefits. How the claim ultimately is processed by your insurance company may differ from what we were told.
- Many insurance companies and all workers' compensation companies REQUIRE PRE- AUTHORIZATION for treatment. Neuro & Brain Performance Centers (NBPC) has no input on the authorization process other than to submit the required forms. You can expedite how soon we can treat you by calling your referring physician's office or insurance company to urge them to initiate or process the necessary paperwork.
- Medicare and other insurers often set limits on physical and occupational therapy benefits. In addition, they require new referrals from your referring physician every 30 days, even if you didn't use the prior month's visits. Please note that Medicare has set a $1,900 per year per patient maximum benefit for physical therapy treatments.
- I hereby give authorization for payment of insurance benefits to be made directly to Neuro & Brain Performance Centers for payment of insurance benefits for services rendered. I also authorize Neuro & Brain Performance Centers to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original.

Initials _____

<u>General Policies</u>

- We try to see our own patients whenever possible; however, on certain occasions when we are not available, we do cross coverage with other qualified professional health care providers. We trust that you will understand and assist in helping us provide you with the best care during these cross coverage periods.
- We do not have facilities to accommodate your small children if they are not receiving treatment. We encourage you not to bring them to the clinic. If you MUST bring your child, for the safety of all present they are not allowed to play on or near any equipment or other patients. You will be personally liable for any damages caused by your children.
- As a courtesy to other patients I agree to mute my personal electronic devices unless I am using personal earphones.

- Please be on time for your scheduled appointments so that you can receive the full benefit of your scheduled treatment. Arriving more than 15 minutes late may result in an abbreviated treatment or cancellation. We require 24 hour advanced notice of cancellation of appointments. Failure to show for an appointment or to cancel without sufficient notice may be subject to a $75 charge to your account.

I provided accurate and complete information requested in this packet. I read and understand the financial responsibility, insurance policies and obligations, and general policies of Brain Performance Centers. I hereby accept those policies and authorize all therapy treatments, which in conjunction with the judgements of the attending physician, may be considered necessary or advisable for the diagnosis or treatment of the above named patient at Neuro & Brain Performance Centers.

_____ _____

Signature of Patient (or of Parent or Guardian if Patient is a minor) Date

Patient Name: _____

HIPAA NOTICE OF PRIVACY PRACTICES – Effective 10/13/2015

Your Information. Your Rights. Our Responsibilities.

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 You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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

Get 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, but we'll tell you 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 on page 1.
- 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 visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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

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, 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

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

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

This section explains our uses and disclosures of your information

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

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.

Run our organization

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.

How else can we use or share your health information?

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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**