NRS
NEUROPSYCHOLOGY
REHABILITATION
SERVICES

LS
LIFE SPAN
Behavioral
Health

www.nrslifespan.com

**Robert. B. Sica, Ph.D., Director**
License # 1519
*Board Certified, American Board of Professional Neuropsychology #255*
*Fellow, American College of Professional Neuropsychology*
*National Register of Heath Service Providers in Psychology*

**Steven P. Greco, Ph.D.**
License # 4517
*Pediatric and Adult Clinical Neuropsychology*
*Board Certified, American Board of Professional Neuropsychology #482*
*Fellow, American College of Professional Neuropsychology*

## Patient Information

Referring Dr. _____ # _____

Primary Care Physician _____ # _____

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State/Zip _____

Email _____

Phone _____ Cell_____ D.O.B. _____ Age _____

S.S. # _____ Employer_____ Phone # _____

Employers Address _____

Spouse's Name _____ Employer _____ Phone # _____

**PLEASE SUBMIT YOUR INSURANCE CARDS SO WE MAY COPY THEM FOR OUR FILE**

**PLEASE REMEMBER ALL INSURANCE CONTRACTS ARE BETWEEN YOU AND YOUR INSURANCE COMPANY. WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY. PAYMENTS OF ANY CHARGES ARE PRESUMED TO BE YOUR RESPONSIBILITY.**
**OFFICE POLICY ON PATIENT PAYMENT: PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED. WE ACCEPT CASH, CHECK, VISA, MASTERCARD & AMERICAN EXPRESS. I HEREBY ASSIGN ALL MENTAL HEALTH BENEFITS, INCLUDING MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, AS WELL AS MEDICARE AND OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO LIFESPAN/NRS. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY SAID INSURANCE. I HEREBY AUTHORIZE LIFESPAN/NRS TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.**

Signature _____ Date_____



**ALL CORRESPONDENCE TO:**
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2100 Route 33, Suite 9-10, Neptune, New Jersey 07753
732-988-3441 | Fax 732-988-7123

**Lakewood Office:**
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**Out of Network Acknowledgement**

Pursuant to the Health Care Consumer Protection Act and in particular the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act", please be advised of the following:

You have elected to treat with a Provider in this office who is **not** a part of your health insurance plan. This is considered **Out-of-Network**. Out-of-Network benefits are a health insurance benefit enhancement for which you, as the insured, pay an additional premium. You have selected an out-of-network provider with full knowledge that the provider does not participate with your insurance plan.

Based upon your particular plan and benefits you may be held responsible for a deductible, co-insurance and/or co-pay that is higher than what an in-network provider will cost. Our standard Procedure Codes and our fees associated with them are set forth below.

90791 Consultation: $380

96130 - 96138 Neuropsychological Examination: $150 - $300 per unit; Total $2850
96130 - 96137 Psychological Examination: $150 - $300 per unit; Total $1400

90834 Individual Therapy (45 min): $200

Depending on your benefits, you may be responsible for the full cost as set forth above. Please contact your carrier should you have any questions regarding your financial responsibility.

I have read and understood the NRS/Lifespan policy for treating with a provider who is Out-of-Network.

Signature _____ Date_____

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**Insurance Information**

Primary Insurance _____ID Number _____

Insurance Phone #_____

Insurance Claims Address _____

Subscriber (if different than patient) _____

Subscribers DOB and relation _____

Secondary Insurance _____ID Number _____

Insurance Phone #_____

Insurance Claims Address _____

Subscriber (if different than patient) _____

Subscribers DOB and relation _____

Please submit your insurance card so we may copy them for our files. Please remember all insurance contracts are between you and your insurance company. We do not render services on the assumption that charges will be paid by your insurance company. Payments of any charges are presumed to be your responsibility.Office policy on patient payment: payment is due at the time service is rendered. We accept cash, check, visa, Mastercard & American Express.

I hereby assign all mental health benefits, including major medical benefits to which I am entitled, as well as Medicare and other government sponsored programs, private insurance, and any other health plan to NRS/LifeSpan. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether paid by said insurance. I hereby authorize NRS/LifeSpan to release all information necessary to secure payment.

Signature _____ Date_____

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**Informed Consent for Treatment**

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided by/at NRS/LS. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. 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.

Signature _____ Date_____



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## Appointment Policy

If you are assigned a weekly appointment with the doctor, biofeedback technician and/or cognitive therapist and should you cancel or no-show for any of these appointments twice during a one-month period, we reserve the right to remove you from this assigned time slot and re-assign it to someone else.

Should you not be able to attend your appointments due to illness or vacation, etc., please let the **FRONT DESK STAFF** know, (**not** your doctor) as soon as possible and we will hold this time slot for you as long as we can.

If we are not informed within a 24-48-hour period that you are canceling your scheduled appointment, you will personally be held responsible for this, not your insurance company. A missed appointment can possibly result in a charge due and payable prior to your next scheduled appointment. If you cannot reach us during regular working hours our answering service is available to take messages after hours and on weekends.

**Cancellation and No-Show fees are as follows:**

| | |
|---|---|
| **Neuropsychological Examination**<br>*Unless 72 hours or more cancellation is received* | $200.00 |
| **Individual Therapy, Biofeedback and/or Cognitive Therapy**<br>*Unless 24 hours or more cancellation notice is received* | $75.00 |
| **No-Show** *for Individual Therapy, Biofeedback and/or Cognitive Therapy* | $100.00 |
| **Check Return Fee**<br>*If check is returned to us more than once, future payments must be paid by cash, credit card or money order.* | $30.00 |

Signature _____ Date_____

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**Release Form**

**PATIENT NAME:** _____

I do hereby authorize NRS Lifespan to discuss my/my child's personal health information including furnishing full reports, medical records, diagnosis, treatment, prognosis, etc., to the following listed below…

For example, please list: Physician (s), Insurance Company, School, Attorney, Significant Other, Parents/Guardians.

If you choose not to release any personal health information, please write N/A and sign below.

_____

_____

_____

_____

_____
Signature (if patient is under the age of 18, parent signature is required)

_____
Date

I, the undersigned, understand that I have the right to revoke this authorization. I understand the revocation must be in writing and bear my signature. My revocation must be submitted to the above healthcare provider. I understand that if I do revoke this authorization, my revocation will not affect any prior actions taken in reliance on this authorization.

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**Outpatient Mental Health Benefits**

Upon scheduling your appointment with NRS/LifeSpan we advise you to verify your health insurance for your outpatient mental health benefits. Many times these benefits are quite different from your medical benefits. The information received from your insurance carrier is not always accurate and is never a guarantee of payment.

If the doctor recommends any further treatment you will need to verify what procedures are covered with your insurance carrier, as well as find out what your copay or percentage responsibility will be. While we will bill your carrier for treatment, if you cannot afford your responsibility it will be your obligation to let us know so we can refer you to another facility or clinic.

Copays are due and payable upon each visit. They are not billed to you. Should at any time you have a copay balance that exceeds $100.00 dollars and you are unable to keep up with you responsibility we reserve the right to cancel future appointments and to refer you to another facility or clinic that maybe more affordable for you.

We strongly recommend every patient to contact your carrier to obtain your outpatient mental health benefits, as ultimately you may be responsible for any balance.

I have read and understood the above information:

Signature _____ Date_____



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## Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made my alternative means, such as sending correspondence to the individual's office instead of the individual's home.

## I wish to be contacted in the following manner (check all that apply):

◯ Home Telephone _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call-back number only

◯ Work Telephone _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call-back number only

◯ Written Communication
- ◯ OK to mail to my home address
- ◯ OK to mail to my work/office address
- ◯ OK to fax to this number

☐ Other _____
_____

_____
Patient Signature

_____
Date

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**Consult Questionnaire**

Name: _____ Age: _____

Date of Birth: _____ Cell Phone: _____

Home Address: _____

Referred By: _____

Presenting Problem (include onset, duration, intensity):

_____

_____

_____

Precipitating Event (why treatment now):

_____

_____

_____

**FAMILY BACKGROUND/CHILDHOOD EXPERIENCES**

1. Please list by first name your parents and and your siblings, including yourself. Give their current ages, and in the column **"Other data"**, list date of death if deceased and/or serious problems, e.g. mental illnesses, alcoholism, head injuries, etc.

_____

_____

_____

Where did you grow up? What was it like?

_____

_____



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Did you feel loved by your parents? Yes◯ or No◯

Where there any traumas in your childhood? Yes □ or No □

Please describe: _____

_____

_____

Do you consider your childhood basically happy◯ or unhappy □?

Why? _____

_____

Describe your education in elementary school, high school and after.

_____

_____

_____

_____

What is your work background/career?

_____

_____

_____

_____

_____



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Include a description of your current job and how you like it?

_____

_____

_____

_____

_____

What is your current living situation? Who lives in your home?

_____

_____

_____

If you are currently in a relationship or marriage, please describe it. If not, please describe your last relationship.

_____

_____

_____

_____

Do you have a support system, friends, family members etc.? Yes □ or No □

Do you have children? Yes or No □

If so, please give gender and ages of each and describe your relationship with them.

_____

_____



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Do you have strong religious beliefs? Yes or No

**PHYSICAL AND MENTAL HEALTH HISTORY**

Do you have any current or past health problems? Yes □ or No □

If so, please describe:

_____

_____

Are you on any medication? Yes □ or No □

Please provide medication names, dosage, dates of initial prescription and refills, and the name of doctor prescribing medication.

_____

_____

_____

_____

Describe your current use of alcohol, tobacco or recreational drugs.

_____

_____

_____

_____

Past Psychiatric History (Mental Health and Chemical Dependency/Hospitalizations)

_____

_____

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Prior Outpatient Therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment, etc)

_____

_____

_____

_____

Family Mental Health or Chemical Dependence History

_____

_____

_____

Please provide information to the following:
General Practitioner Name and Number

_____

Neurologist Name and Number

_____

Any other physician _____

If there is any other information you would like the doctor to know, please provide at this point.

_____

_____

_____

_____

Thank you,
NRS Staff



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