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._____

Email _____ Email _____

Address _____ City _____ State/Zip _____

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

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_____

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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.

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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_____

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

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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 *Unless 72 hours or more cancellation is received*	$200.00
Individual Therapy, Biofeedback and/or Cognitive Therapy *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 *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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Dear Parents or Guardian:

The initial process in the evaluation of your child will begin with the completion of the attached developmental questionnaire.
It is important to answer all of these items contained on the form. The form is detailed and lengthy, but the information requested will be a valuable and an integral part of the evaluation procedure.
Thank you for your assistance and cooperation.
The Staff at NRS|LifeSpan

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IDENTIYING INFORMATION

Child's Name: _____ Sex: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Parent #1: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Highest Level of Education: _____ Occupation: _____

Parent #2: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Highest Level of Education: _____ Occupation: _____

Marital Status of Parents: _____

Custody Arrangement (if applicable): _____

REFERRAL INFORMATION

Referred by: _____ Address: _____

Phone: _____ Reason for Referral: _____

OTHERS LIVING IN THE HOME

1. _____ Relationship _____ Age: _____
2. _____ Relationship _____ Age: _____
3. _____ Relationship _____ Age: _____
4. _____ Relationship _____ Age: _____

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5. _____ Relationship _____ Age: _____
6. _____ Relationship _____ Age: _____
7. _____ Relationship _____ Age: _____

Other immediate family not currently living in the home (siblings away at collage or living independently, etc.): _____

Primary language spoken at home: _____

SCHOOL INFORMATION

Current School: _____

City: _____ County: _____ Grade Level: _____

Is this a new school? _____ If not, how long enrolled here? _____

Please describe any academic difficulties (reading, writing, spelling, math, comprehension, etc.)

_____

_____

Please describe your child's grades and academic performance:

_____

_____

Has child every been evaluated by a Child Study Team? _____

Is yes, why? _____

When? _____ Where? _____

Results? (Please bring/email copies of these evaluations prior to the consultation)

_____

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Does your child have a 504 plan, IEP, or Service Plan currently? If yes, please describe the reasons and services that are included. (Please bring copies or email them):

_____

_____

Other than those described above, does your child receive any other services at school (psychical therapy, occupational therapy, speech therapy, small group instructions, gifted & talented programming)?:

_____

_____

Please describe your child's social abilities including his/her interactions with others, reciprocal play skills, friendships, etc.:

_____

_____

Please describe any comments that teachers have shared regarding your child (behaviors in the classroom, observations, checklist results, concerns about attention, behavior, social skills):

_____

_____

What are your child's strengths (both in and outside of school)?:

_____

_____

What activities does your child enjoy/participate in (both in and outside of school)?:

_____

_____

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PURPOSE OF EVALUATION

Briefly describe the present problem for which you are seeking an evaluation.

_____

_____

When did you first become concerned about your child's issue?

_____

_____

_____

What are you hoping to gain from consultation and/or evaluation?

_____

BEHAVIOR

Please rate your child's behavior using the following scale:

0 = No problem
1 = Moderate problem
2 = Definite problem
3 = Extreme problem

____ High activity level-very active, restless, fidgety, easily stimulated

____ Impulsive, often loses control, calls out in class.

____ Aggressive with parents, siblings and/or peers.

____ parents

____ siblings

___ peers

____ Has trouble concentrating, focusing and paying attention.

____ Sluggish, complains of being tired

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____ Sadness, cries easily, depressed

____ Irregular mood swings.

____ Anxiety, frequent worries

____ Unusual fears or phobias (i.e., dogs, dark). If yes, specify: _____

_____

____ Oppositional tendencies, including tantrums (verbal, physical, etc.)

____ Sleep difficulties (falling, staying in his/her own bed, nightmares)

____ Eating difficulties (picky eating, eating too much/too little)

____ Difficulty getting along with peers

____ Motor difficulties (coordination, gross, fine, etc.)

____ Does not adapt well to new things or situations

Did a significant event occur prior to the onset of any of these problems (divorce, illness/death of a family member, birth of sibling, change of residence/school, etc.):

_____

_____

DEVELOPMENTAL HISTORY

1. Any problems during prenatal period (early labor, bleeding, etc.)?

   _____

2. Please describe your child's delivery (including natural/C-section, APGAR scores, weight, height, birth complications:

   _____

   _____

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3. Any postnatal complications (NICU, special care, release home with mother, etc.)

_____

4. Please describe early developmental history including age of crawling, walking, talking, toilet training, etc.:

_____

_____

5. Does your child currently have a medical/neurological/psychiatric diagnosis? Or is she/he being treated for any condition? (list all)

_____

_____

6. Has your child ever been hospitalized or had surgery? (if yes, list when and describe):

_____

_____

7. Has your child ever had a head injury/ concussion?

_____

_____

8. Has your child ever had a seizure or any other neurological problems?

_____

_____

9. Has your child ever been evaluated by Optometry, Ophthalmology, or Audiology?

_____

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10. Please describe any other physical complaints your child has (stomachaches, headaches, hearing/vision/speech issues, dizziness, infections, asthma, heart murmur, vocal/motor tics):

_____

_____

11. Does your child have any significant allergies, particularly any that our office should be aware of prior to his/her appointment?

_____

_____

12. Does your child have any sensory issues (increased or decreased sensitivity to sounds, temperature, textures, clothing?

_____

_____

13. Past medications:

_____

14. Current Medications:

_____

15. Has your child ever seen a Neurologist? If yes, list when, describe why, and indicate the results. Please provide copies.

_____

_____

16. Has your child ever seen a Psychologist or Counselor? If yes, list when and why.

_____

_____

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17. Has your child ever seen a Psychiatrist? If yes, list when and why. Also indicate any medications that were prescribed.

_____

_____

18. Has your child ever had any inpatient psychiatric hospitalization, partial care/residential treatment, or been in a crisis center? If yes, list when, why, and indicate outcome.

_____

_____

19. Are you aware of any use of tobacco, vaping, alcohol, marijuana, or other substances by your child?

_____

_____

20. Has your child ever been treated by a professional for substance abuse?

_____

21. Has your child ever made statements about hurting himself/herself, suicide, or hurting others? If yes, list when and describe.

_____

_____

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FAMILY MEDICAL HISTORY

Has anyone in your child's biological family (parents, grandparents, siblings, aunts, uncles, cousins) ever had ADHD, learning disabilities, intellectual disabilities, developmental delay, autism, seizures/epilepsy, or any other neurological conditions?

_____

_____

_____

Has anyone ever had depression, anxiety, obsessive-compulsive behavior, bipolar disorder, oppositional behavior, substance abuse, etc.?

_____

_____

Any other additional comments or concerns you would like to share?

_____

_____

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