**Barbara L. Cohen, PsyD**
**Clinical Neuropsychologist**

# REGISTRATION FORM

## PATIENT INFORMATION:

Name: _____
Address: _____
_____
Patient Phone Number: (home) _____
(work) _____
(cell) _____
(please indicate preferred contact phone number)
Patient Date of Birth: _____
Patient SSN: _____

## PERSON RESPONSIBLE FOR THIS ACCOUNT:

Full name of subscriber: _____
Date of birth of subscriber: _____
Relationship to Patient _____
Home Address and Phone Number (if different than patient's): _____
_____
SSN: _____
Employed by: _____
Business Address and Phone Number: _____
_____
Occupation: _____
(If patient or guardian is not responsible for this account, arrangements must be documented)

If patient is a child and parents live separately:
Name of other parent: _____
Address: _____
_____
Phone Number: _____
Date of Birth: _____
SSN: _____

## INSURANCE INFORMATION:

Name of Primary Insurer: _____
Contract # _____
Group # _____
Name of Secondary Insurer (if any): _____
Contract # _____
Group # _____

## ADDITIONAL INFORMATION:

Emergency Contact: (name) _____
(phone number) _____
Referral Source: _____

If you would like information released to a Doctor or other person, please ask for a Release of Information form.

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## CONSENT TO TREATMENT

By signing this form, you, the patient, are agreeing to enter into treatment with me as your doctor.

Patient/Guardian Signature: _____
Date:_____

## USE OF PRIVATE HEALTH INFORMATION

This form is to make you, the patient, aware that private health information may be shared, as necessary, with others in my practice. Please read and sign this form which outlines the use of private health information.

I maintain responsibility for billing insurance companies for services which I have provided. Information which is released to insurance companies varies and depends upon the specific information required by the contract between the patient and the insurance company. I provide information as required, which typically includes dates of services, types of service, and diagnosis. If a bill is unpaid, such as an insurance company not covering these services, and you, the patient, do not pay the bill, I may contract with a collections agency for payment. Only information which is necessary for payment will be shared. If you do not want information shared, then you have the option of paying for services yourself rather than having me submit them to your insurance company.

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without your authorization or without legal authority unless I (the covered entity) can show that there was a low risk that the Protected Health Information (PHI)) has been compromised because the unauthorized person did not view the PHIL or it was de-identified.

If you are self-pay, then you may restrict the information sent to insurance companies.

Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. You must sign an authorization (release of information form) for releases that are not mentioned in this Privacy Notice unless such releases are required by law (i.e. mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc).

You have a right to receive a copy of your Protected Health Information in a electronic format or (through a written authorization) designate a third party who may receive such information.

By signing this form, you, the patient, are agreeing to allow me to use Private Health Information as outlined above.

Patient/Guardian_____
Date:_____

**211 S. Route 100**
**Allentown, PA 18106**
**610-530-0100**

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## GUARDING SECURITY OF CONFIDENTIAL INFORMATION

In order to comply with specific rules regarding HIPAA (Health Insurance Portability & Accountability Act of 1996), please review and sign a privacy and security health information document.

It is my policy not to release confidential and/or unauthorized information without specific consent by the patient/guardian.

The purpose of this form is to identify ways in which you, the patient, would like general information to be handled. This may include a response by email, return phone calls or calls which I initiate to you. These calls may be made to a home telephone, answering machine, work telephone, voice mail, cell phone, and/or pager. Please be aware that wireless communication is vulnerable to breaches and may not be confidential. Please be aware that if you request that information to be shared only with you directly rather than leaving a message, this may affect the timeliness in which I can respond to any requests which you make.

By completing this information and signing this form, you (the patient) are authorizing me (Barbara L. Cohen, PsyD) to leave information pertaining to general information, such as having received a phone call or request to make a return phone call.

| | | | |
|---|---|---|---|
| Home Telephone | _____Yes | _____No | _____N/A |
| Answering Machine | _____Yes | _____No | _____N/A |
| Work Telephone | _____Yes | _____No | _____N/A |
| Voice Mail | _____Yes | _____No | _____N/A |
| Cell Phone and/or Voice Mail | _____Yes | _____No | _____N/A |
| Pager | _____Yes | _____No | _____N/A |
| Email | _____Yes | _____No | _____N/A |

For deaf patients: Do you want me to use the relay system to initiate or respond to a phone call? _____Yes _____No_____N/A

If you prefer, please indicate how you would like me to handle general information such as phone calls.

_____
_____
_____
_____

Please list names of any individual with whom you would prefer me not to leave information:

_____
_____
_____

Patient/Guardian Signature:_____

Date:_____

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## CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of my Privacy Practices is available for review in the waiting room. If you would like a copy for yourself, please inform me.

Print Name: _____

Signature: _____

Date: _____

**Barbara L. Cohen, PsyD**
**FINANCIAL RESPONSIBILITY**

Please read and sign this form which outlines financial responsibility for treatment.

1) The patient/guardian is financially responsible for services received.

2) Financial responsibility can be met if insurance benefits cover the services. Covered services are specific to your insurance plan. It is your responsibility to understand the benefits and requirements of your insurance plan. You may be required to obtain initial authorization or referral from a physician. Denials by your insurance company due to lack of pre-authorization or referral are your responsibility. You may be required to pay a portion of the fee (co-pay). It is your responsibility to inform me of any changes to your insurance. Insurance companies pay only for treatment that is medically necessary. Additional or other services may not be covered. Contracts with most insurance companies typically identify that a final determination of medical necessity is made by the insurance company. Services specifically requested for or related to a job, education, or legal proceedings may not be covered. As the patient/guardian you are ultimately responsible should your insurance not pay for services.

3) If you chose to use insurance benefits to pay for services, I will be required to provide information to the insurance company. Depending upon the insurance company, information is likely to include diagnoses. Symptoms, treatment plans and other information may be required. Once information leaves my office, I cannot control how it is used. If you chose not to share information with your insurance company, they may not reimburse the services you are receiving.

4) I expect you to come for your therapy and evaluation sessions. Cancellations are understood to happen only occasionally. Routine cancellations are not accepted and will be discussed as a therapeutic issue. If a cancellation is unavoidable, notice is required.

a) If I 'hold' an appointment for you, I have saved that time for you. It is your responsibility to inform me if you cannot make this appointment. I ask that you do this as soon as possible, at least within 2 business days. If I do not hear from you that you do not want this appointment, I will understand that you have agreed to this appointment time. Cancellation is then required.

b) Please inform me directly of cancellations. I may not get a voice mail or email message and then I will not know that you have cancelled. If you leave a message, do not verify it has been received, and I do not know you have cancelled, you will be charged for the appointment.

c) For Psychotherapy: Cancellations require at least 2 business days notice. If appointments are cancelled with less than 2 business days notice, you will be charged the full fee as insurance companies do not pay for services not received.

d) For Evaluations: 2 business days notice for each hour reserved is required. For example, if your appointment is scheduled for 2 hours, then 4 business days advance notice is required. If you do not cancel with advance notice, you will be charged for the full fee as insurance companies do not pay for services not received.

5) Your appointment is for a specific day and specific time. If you request a change in the time or day of your appointment, you are still responsible for the originally scheduled appointment unless cancellation procedures have been followed.

6) Payment is expected at the time of service unless specific arrangements are agreed upon in advance. I do not send out bills. If needed due to insurance processing, I will write to inform you of an amount you owe. There is no charge for the first letter. If your bill remains unpaid and I need to write further letters, there is a charge of $15 per letter. Interest charges or late fees may be incurred for unpaid balances over 30 days (at the rate of 1% interest/month or $5/month whichever is greater). If a balance remains unpaid, I may seek help in collecting unpaid amounts from a collection agency or an attorney. You agree to reimburse me the fees of any collection agency, which may be based on a percentage at a maximum rate of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, I incur in such collection efforts.

7) There is a fee for extended phone calls or emails. In most cases, this is generally greater than 10 minutes in length. The fee will be based on the time used and billed at my regular hourly rate. If phone calls are frequent, a fee may be charged even if less than 10 minutes.

8) There is a charge for extended travel. Generally, travel time greater than 10 minutes total will be charged. The fee will be based on the time used and billed at my regular hourly rate.

9) If you request copies of information sent to another source or if you have given another source permission to review evaluations or other reports, there will be a charge for copying and mailing. If I write a letter on your behalf, there will be a fee if it requires greater than 10 minutes of my time.

By signing below, you, the patient, understand and accept the policies I have outlined.

_____ _____

Patient Signature Date

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**Clinical Neuropsychologist**

## Liability Acknowledgement Form

There may be reasons why your insurance company does not cover services which you request and I provide. While I do not expect this to happen, if your insurance company denies payment, you, the patient or guardian, agree to be financially liable for and pay all charges.

There are different reasons why service may not be covered. These include:

- a service that is a non-covered benefit
- a service that your insurance company has determined to be not medically necessary
- a service which requires preauthorization which was not obtained prior to the date of service
- a service for which a claim was submitted but not recognized as received by your insurance company ("untimely filing")
- other reasons specific to your insurance company

By signing below, you, the patient or guardian, understand and accept the financial responsibility for services.

_____ _____

Patient Signature Date