

# Health Insurance Portability and Accountability Act (HIPAA)

Disclosure of personal and clinical information gathered about you through assessment and therapy services is regulated by HIPAA as well as other applicable laws to ensure the privacy of your protected health information (PHI).

We only disclose your PHI with your written consent, court order or as allowed by HIPAA to provide you with appropriate care, or as allowed or required by law. Information released will be that which is minimally necessary to meet the purpose at hand.

You, as the patient, have the right, through written request, to disclose, revoke, assess, review and request correction of your PHI and to receive copies of your records for a nominal charge.

HIPAA compliance is regulated by the U.S. Department of Health and Human Services. You have an opportunity to review the complete HIPAA statement.

\_\_\_\_\_  
Patient Signature(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Empowered Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# Release of Information Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**IMPORTANT NOTE:**

*This form is optional. However, this form is necessary if you want Dr. Saldukas to be able to communicate with or release your information to ANYONE – this includes family members. Also, you must have a separate form for EACH person you are authorizing your release of information for.*

**AUTHORIZATION:**

I authorize Dr. Saldukas to communicate verbally or in writing with the following party on my behalf. I also authorize the following party to release to Dr. Saldukas my related information as requested.

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Information to be released (*please initial by all items below that apply*):

Assessment Data: \_\_\_\_\_

Neuropsychological or Psychological Test Results \_\_\_\_\_

Progress in Therapy \_\_\_\_\_

Treatment/Discharge Summary: \_\_\_\_\_

**REVOCATION:**

You understand that this consent is valid until you revoke it in writing, which you may do at any time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian or Lawful Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# Consent for Assessment and/or Treatment

\_\_\_\_\_  
(Initial here) I voluntarily consent to assessment and/or treatment services from Dr. Saldukas who is in independent practice located at 1044 Castello Drive #210, Naples, FL 34103. I acknowledge that I have had the opportunity to ask questions of my provider particularly in regard to diagnosis, assessment and treatment procedures, risks/benefits associated with those procedures, and exceptions to confidentiality.

\_\_\_\_\_  
(Initial here) **I certify that I am NOT seeking assessment and/or treatment services in connection with any legal issue, current or contemplated.** If you are seeking court-related services, you may wish to schedule an assessment with another practice that has a board-certified forensic psychologist or forensic neuropsychologist.

I have read and understand the above information. I also understand that I can withdraw my consent and authorization for treatment, either verbally or in writing, at any time.

\_\_\_\_\_  
Patient Signature(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian or Lawful Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name(s):

## Late Cancel/No-Show Policy

**A \$100 fee will be charged for all appointments that are cancelled or changed without 48-hours' notice; this includes "no-showing" for scheduled appointments.**

This fee is NOT covered by insurance, and patients will be expected to pay this fee before their next appointment.

This fee does NOT apply to the first time an appointment is canceled or changed without giving 48-hours' notice, the first time an appointment is missed without notice ("no show"), or if there are extreme circumstances that caused the occurrence.

We appreciate your cooperation in this important matter. By providing us with 48-hours' notice to cancel or change your appointment, we are better able to provide more immediate care when urgent issues arrive.

I confirm receipt of the above policy:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Empowered Representative

\_\_\_\_\_  
Printed Patient Name

# Financial Policy

Please review the financial policy below carefully.

1. All applicable payments are due in full at the time of service, including, but not limited to co-payments, deductibles, and non-covered services. Until your deductible is met, you are responsible to pay the full contracted rate per appointment.
2. For Medicare beneficiaries, we accept assignment on Medicare claims and any secondary carrier you might have. For other insurance that we contract with, we are pleased to file a claim for you based upon information you provide to us in your initial paperwork. Should your insurance information changes, you are responsible to let us know so that claims can be submitted correctly. Should a duplicate payment be received, it will be refunded to you by check or credited to future balances owed within a reasonable timeframe.
3. Although we are pleased to submit your claims to your insurance, payment for the services you receive are ultimately your responsibility if your insurance fails to pay. Also, you are responsible for any needed pre-certification of services unless we, as your provider, are required by contract to perform this service.
4. You authorize Steven W. Saldukas, Ph.D., PA to keep your credit card, FSA or HSA number on file, and to charge it to clear any outstanding balances.
5. You are responsible for all services provided that are not regularly covered by your insurance. These services include, but are not limited to letters to the court, documents not directly related to services provided, phone calls, missed appointment charges, etc. Each missed appointment or appointments not cancelled 48 hours prior to appointment time are billed at the rate of \$100 per occurrence.
6. Non-payment of services may result in collection and legal proceedings and a charge for respective fees. All charts automatically close 90 days after the last scheduled appointment.
7. You give permission to release information from treatment records necessary to process my claims with my insurance carrier(s) or any third party involved in the processing of my claim.

Your insurance policy is a contract between you and your insurance company, and in some instances, your employer, and in no way guarantees payment for the services you receive.

When Dr. Saldukas is an authorized provider by your insurance carrier's network, it simply means that you are entitled to "in-network" benefits at the participating provider rates. It does NOT guarantee that he will be compensated by your insurance provider.

Accordingly, Dr. Saldukas CANNOT guarantee coverage of his services, in part or in full, by your insurance provider even if a prior authorization was received. Insurance company policies are subject to change without notice. Accordingly, any discrepancies between the reimbursement received by Dr. Saldukas and the contracted rate for the services performed are your responsibility to resolve with your insurance company.

*Financial Policy continued...*

Therefore, you acknowledge that Dr. Saldukas is providing a requested service to you for which he is entitled to be paid. You also acknowledge that you are responsible for the payment of these services in the event that your claim(s) is/are denied in part or in full by your insurance provider.

For your convenience, we accept cash, check or credit cards (Visa, MasterCard, AmEx, and Discover) including Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA).

You have read, understood and agree to the financial policy outlined above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Guardian or Lawful Representative Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Registration Form

Please Print Clearly

## CONTACT INFORMATION:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternate Address: *(if seasonal)* \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Which phone numbers can we leave a message? *(check all that apply)*  Home  Work  Cell

E-mail Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## REFERAL INFORMATION:

Referring MD Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## PATIENT INFORMATION:

Marital Status:  Married  Divorced  Widowed  Single

Spouse/Guardian Name: \_\_\_\_\_

Highest School Completed: \_\_\_\_\_

Current Employment Status:  Working  Retired

Primary Occupation: \_\_\_\_\_

Primary Care MD: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

## INSURANCE INFORMATION: *(please print clearly or provide copies of your cards)*

### **PRIMARY Insurance:**

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

ID: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### **SECONDARY Insurance:**

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

ID: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### **Financially Responsible Person: *(if different from patient)***

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_