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 had the opportunity to review the complete HIPAA statement.

_____ _____
Patient Signature(s) Date

_____ _____
Empowered Representative Date

_____ _____
Witness Signature Date

Steven W. Saldukas, Ph.D., PA
1044 Castello Drive # 210, Naples, FL 34103, Phone: 239-304-9026, Fax: 239-304-9749; www.psychcareswfl.com

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

Steven W. Saldukas, Ph.D., PA
1044 Castello Drive # 210, Naples, FL 34103, Phone: 239-304-9026, Fax: 239-304-9749; www.psychcareswfl.com

Consent for Assessment and/or Treatment

Your physician has referred you to Dr. Saldukas for an assessment of your current cognitive functioning. This assessment is designed to assist your physician with your ongoing care. However, this assessment is **not intended or designed to meet the requirements of a forensic (court-related) evaluation,** as required for legal actions and/or court-related matters.

IMPORTANT: 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.

_____ (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.**

_____ (Initial here) **I understand that I was referred for evaluation to assess my current level of cognitive functioning for the sole purpose of assisting me with my plan of care.**

_____ (Initial here) **I understand that this report is not intended or designed to meet the requirements of a forensic (court-related) evaluation, as required for legal actions and/or court-related matters.**

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):

Steven W. Saldukas, Ph.D., PA

1044 Castello Drive # 210, Naples, FL 34103, Phone: 239-304-9026, Fax: 239-304-9749; www.psychcareswfl.com

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

Steven W. Saldukas, Ph.D., PA

1044 Castello Drive # 210, Naples, FL 34103, Phone: 239-304-9026, Fax: 239-304-9749; www.psychcareswfl.com

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. Assessment services (90791) - $250 per session; Individual therapy sessions of 45 to 50 minutes' duration (90834) - $200 per session; Family therapy sessions without patient present (90846) - $200 per session; Family therapy with patient present (90847) - $200 per session; Psychological testing (96101 and 96118) - $200 per hour.
6. 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 in excess of 15 minutes, missed appointment charges, etc. All services except missed appointments will be billed at the rate of $300 per hour prorated based on 15-minute increments. Each missed appointment or appointments not cancelled 48 hours prior to appointment time are billed at the rate of $100 per occurrence.
7. 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.
8. 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, Saldukas CANNOT guarantee coverage of his services, in part or in full, by your insurance provider even if authorization was provided. Insurance company policies are subject to change without notice. Accordingly, any discrepancies between the actual claim payment and the benefits quoted are your responsibility to resolve with your insurance company.

Steven W. Saldukas, Ph.D., PA
1044 Castello Drive # 210, Naples, FL 34103, Phone: 239-304-9026, Fax: 239-304-9749; www.psychcareswfl.com

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: _____

Steven W. Saldukas, Ph.D., PA
1044 Castello Drive # 210, Naples, FL 34103, Phone: 239-304-9026, Fax: 239-304-9749; www.psychcareswfl.com

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: _____

Steven W. Saldukas, Ph.D., PA

1044 Castello Drive # 210, Naples, FL 34103, Phone: 239-304-9026, Fax: 239-304-9749; www.psychcareswfl.com