SERENITY NEUROPSYCHOLOGY, PLLC

2498 N. Stokesberry Pl., Ste. 150, Meridian, ID 83646
208-957-5450 (phone); 208-957-5292 (fax); www.idahoserenitycounseling.com

PATIENT REGISTRATION

Date_____ Person Completing Form (if not patient)_____

Patient Name_____ Date of Birth_____ Age_____ Gender _____

Marital Status ____Married ____Partnered ____Widowed ____Divorced ____Separated ____Single

Spouse/Parent's Name_____ DOB (**if spouse/parent is insurance subscriber**)_____

Dr. Snider strives to offer culturally competent treatment, and thus, the next question is very helpful.

RACE: ____Decline **OR** Identify ____ American Indian/Alaska Native ____ Black/African American

____Asian ____ Native Hawaiian/Other Pacific Islander ____Hispanic or Latino ____Caucasian/White

ETHNICITY: ____Decline **OR** Identify ____Hispanic Origin ____Latino Origin ____Non-Hispanic Origin

Address_____

Address and Person to send statements, **if different from above**_____

Home Phone_____ Cell Phone_____

Do we have permission to leave a voicemail that may include confidential information? Home Y N Cell Y N

Primary Care Physician_____ Referring Provider_____

I consent that Melody L. Snider, Ph.D., owner of Serenity Neuropsychology, PLLC, may contact and leave messages with the following individual(s) for emergency reasons, billing, and/or scheduling purposes and that such contact, may need to include pertinent clinical information with limited disclosure to necessary information.

Name_____ Relationship_____

Phone _____

Name_____ Relationship_____

Phone _____

_____ _____

(Patient or Legal Guardian Signature) (Date)

EMAIL/TEXT CLAUSE

Our credit card processor allows receipts to be sent via email or text. Other communication via email/text may be used for cancellations, appointment reminders, or general communication. Minimally necessary information will be provided via email and/or text and you are asked to respect your own confidentiality. Please **DO NOT** mention personal details about your history or concerns. **The business phone number, 208-957-5450, DOES NOT receive text. Dr. Snider's personal cell phone may be used for text and will be provided on an individual basis.** Data rates may apply. I agree to receive such communication via: **text** Yes No **email** Yes No

If agreeing to email communication, clearly print Email address:_____

_____ _____

(Patient or Legal Guardian Signature) (Date)

MEDICAID CLAUSE

I understand Dr. Snider is not in network with Medicaid and does not treat patients who have Medicaid. I agree if I have Medicaid, then I will need to be referred to a different provider.

_____ I DO _____ I DO NOT have MEDICAID coverage or benefits.

_____ _____

(Patient or Legal Guardian Signature) (Date)

LEGAL & WORKER's COMPENSATION CLAUSE

I understand Dr. Snider does not engage in legal or worker's compensation (WC) cases. I agree I am not involved in any legal conflicts/legal cases. I further agree I am not seeking treatment for issues in which I am involved in a legal suit or WC claim. I do not presently or in the future foresee the need to require representation in court. I understand Dr. Snider reserves the right to terminate our professional relationship and refer me to another provider in the event my treatment becomes of such a nature, in order to provide me with appropriate care.

_____I Am _____I Am NOT involved in a legal suit OR Worker's Comp case.

_____ _____

(Patient or Legal Guardian Signature) (Date)

DISABILITY and LIFE INSURANCE CLAUSE

Dr. Snider MAY assist with disability claims, on a case-by-case basis, by sending the report, with a release, for the length of time she keeps your report (7-10 years depending on your insurance). Additional charges may apply (see patient-psychologist agreement). Dr. Snider does not perform disability evaluations. Therefore, she **will not make a formal opinion about whether an individual qualifies for disability benefits**. If needed, a separate evaluation can be pursued with a provider/agency who performs disability evaluations. Dr. Snider **will not complete any disability related forms** (e.g., ST or LT disability forms via your employer, disability policy through an insurance, any company responsible for processing your disability claim). We also **will not complete life insurance related documents/forms**. With a release, on a case-by-case basis for life insurance benefits, we MAY send the report for the length of time the report is kept as noted above. No legal testimony/deposition will occur. Serenity Neuropsychology, PLLC and Dr. Melody Snider cannot guarantee the outcome of your disability and/or life insurance claim and are not to be held responsible for the outcome.

_____I Am _____I Am NOT currently involved in pursuing disability and/or life insurance benefits.

_____ _____

(Patient or Legal Guardian Signature) (Date)

INSURANCE INFORMATION

Please read and initial each of the following statements. Check if NO INSURANCE COVERAGE _____

_____ 1) Dr. Snider requires a physician's referral for neuropsychological and psychological testing. Patients may self-refer for counseling, though medical records may be requested, with your release, to facilitate treatment. We may also need to provide written counseling updates at times to your specialists and/or prescribing provider(s).

_____ 2) Dr. Snider provides insurance verification. You are strongly encouraged to check your own benefits, coinsurance, copayments, and deductibles that may result in significant out of pocket responsibility. Calling your insurance company will assure you are fully aware of what your treatment will cost to you personally. Possible evaluation billing codes include 90791, 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137. Possible counseling billing codes include 90791, 90832, 90834, and 90837. Check your benefits based on "**in an office setting, not in a facility**."

_____ 3) Dr. Snider will attempt to determine specific insurance limitations such as waiting periods,

preauthorization, and pre-existing condition clauses that may result in denial of your claim. However, you are strongly encouraged to check these factors as we are limited to the information given during insurance verification. The insurance verification we receive is not a guarantee of payment.

_____ 4) If your coverage depends on preauthorization from your insurance company, Dr. Snider will obtain the preauthorization if your insurance allows this. Certain insurance companies require your primary care physician to send the preauthorization. This will be determined to the best of our ability during the insurance verification process.

_____ 5) We require that you provide information for **ALL** insurance coverage. Failure to provide this information will result in being personally responsible for claims denied by your insurance company due to failure to file a claim in a timely manner and/or due to lapse in coverage.

_____ 6) We require an updated copy of any new insurance cards in the event your insurance plan changes. Changes in insurance policies may result in the need to transfer care to a different provider if Dr. Snider is not in network with the new company. Failure to provide this information in a timely manner may result in your claim getting denied, making full payment your responsibility.

_____ 7) Unless other arrangements have previously been made, copayment, coinsurance, and payment for non-covered procedures are due at time of service. Most patients prefer to also pay toward their deductible (if required by insurance as part of patient responsibility) at the time of service to prevent becoming delinquent or having increased balances due all at once. Otherwise, the remaining portion of the patient responsibility, as determined by insurance, will be due within 30 days of balance-due-statement. Statements are sent after the insurance explanation of benefits (EOBs) have been received by Serenity Neuropsychology, PLLC. Excessive unpaid balances are grounds for termination. In the event a patient terminated with an unpaid balance and wishes to return for treatment, the balance will need to be paid in full before scheduling further treatment.

IF YOU ARE USING YOUR HEALTH INSURANCE, PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW.

I hereby authorize my psychologist, Dr. Snider, to release information necessary for billing purposes or for processing my claim. Dr. Snider uses Office Ally to process bills and schedule appointments. I authorize exchange of my protected health information in order to process an insurance claim, provide me with statements, and facilitate reimbursement. I authorize my insurance company to send payment directly to Dr. Melody Snider or to her clinic listed on the claim at 2498 N. Stokesberry Pl., Ste. 150, Meridian, ID 83646 for all provided services. I also assign benefits to Dr. Snider that I may directly receive that are otherwise payable to her or her clinic for services she provided. I understand Dr. Snider is a solo practitioner and is responsible for the legal handling of my protected health information. I understand that I will also be required to sign a HIPAA document/Notice of Privacy Practices.

I understand I am financially responsible for any balance not covered by my insurance carrier. Regardless of insurance benefits, I understand I am responsible for my bill.

_____ _____

(Patient or Legal Guardian Signature) (Date)

BILLING INFORMATION

If Patient is personally responsible for their bill, check the blank and then Skip this section_____.

If someone other than the patient is responsible for the bill, complete this section:

Name_____ (person responsible) Relationship to Patient_____

Mailing Address_____

Preferred Phone_____ Employer_____

I give permission for the above individual to be billed for my care.

_____ _____

(Patient or Legal Guardian Signature) (Date)

**** If the patient is not the subscriber, we need additional information below to adequately bill.** Otherwise, you may leave blank any information that is presented on your card and only include information we are unable to obtain from a copy of your card. We require a copy of your insurance card and a form of identification.

Primary Insurance Company_____

Mailing Address_____

Policy/Member Number_____ Group Number_____

If Subscriber is NOT the patient, please complete the following name and birth date for the policy subscriber:

Policy Subscriber_____ Birth Date_____

Secondary Insurance Company_____

Mailing Address_____

Policy/Member Number_____ Group Number_____

If Subscriber is NOT the patient, please complete the following name and birth date for the policy subscriber:

Policy Subscriber_____ Birth Date_____

Do you have any other health insurance? YES NO

WE RESERVE THE RIGHT TO CHARGE $50 FOR APPOINTMENTS IN WHICH YOU DO NOT SHOW OR FOR WHICH YOU DO NOT CANCEL WITHOUT A 24 HOUR NOTICE.

Non-emergent situations such as but not limited to conflicting appointments, work conflicts/meetings, or failure to remember your appointment may be charged the fee.

Emergency Exceptions

The above charge may not apply in last-minute situations such as if you have car trouble, sick family member, personal illness, or inclement weather. We will waive the charge for late cancellations if you are experiencing an illness that is likely contagious or could cause you to be unsafe while driving to your appointment.

Even in emergency situations, you MUST still call to cancel or you will be charged the $50.

Failure to adhere to this no-show/late cancellation policy may result in Dr. Snider cancelling your future appointments and/or may result in losing your privilege to maintain a standing appointment.

If you no-show and/or late cancel for non-emergent situations for 3 or more appointments in 2 consecutive months, Dr. Snider will consider whether you are committed to treatment and reserves the right to terminate your treatment.

Regardless of the reason, emergent or non-emergent, excessive cancellations and no-shows interrupt treatment and may lead to termination.

_____ _____

(Patient or Legal Guardian Signature) (Date)