Gordon Teichner, Ph.D., ABPP
Allison Adams, Psy.D.
Michael Sugarman, Ph.D.
Cassidy Arnold, Ph.D.

1459 Stuart Engals Blvd., Suite 204A
Mount Pleasant, SC 29464
(843) 849-9913
(843) 881-6878 (fax)
charlestonneuropsychology.com

PATIENT REGISTRATION

Date of First Visit: _____

Legal Name of Patient:_____ Maiden Name:_____
(First) (MI) (Last)
Patient's Date of Birth:_____/_____/_____ Age:_____ Sex:_____ Marital Status:_____ Race:_____

Patient's Social Security Number:_____
Driver's License #:_____ State:_____

Patient's Home Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Email:_____

Name and Address of Patient's Employer:_____
Work Phone:_____ May we contact you at work? Yes/No

Account Guarantor (Person responsible for the bill)/Name:_____

Address:_____
Phone Number:_____ Social Security Number:_____

Relationship to Patient:_____

Guarantor's Employer/Name:_____
Address:_____Phone:_____

If patient is a child or adolescent:
Name of Mother:_____ Name of Father:_____
Social Security # of Mother:_____ Social Security # of Father:_____
Phone # & Address:_____ Phone #&Address:_____
_____ _____

Referred to this office by:_____

Name, Address & Phone Number of Family Physician and /or Referring Doctor:

_____

BILLING INFORMATION: Please read carefully and sign acknowledging your understanding of the policies and your agreement to accept financial responsibility for all charges.

An appointment has been reserved for you. It is very important that you contact us at least 24 hours in advance if you are unable to keep a scheduled appointment. It will be necessary to bill you personally the full amount for failure to cancel your appointment within 24 hours.

Payment in full is expected at the time of service. We accept cash, personal checks, and a number of credit cards. Unfortunately, there will be a $20.00 service charge on all returned checks.

IN ORDER TO FILE YOUR INSURANCE, PLEASE COMPLETE THE FOLLOWING

Account Guarantor:_____
Relationship to Patient:_____ Date of First Visit:_____

INSURANCE INFORMATION: In order to file your insurance we must have a copy of the front and back of your current insurance card. It will also be necessary to verify your benefits for our services and to precertify your coverage. By doing so, it is not a guarantee of payments by most insurance companies. Therefore, the guarantor will be responsible for payment in full if your insurance company does not pay for billed services. In the event that this account is turned over to collections due to an unpaid balance, the account guarantor hereby agrees to pay all costs of collection including, but not limited to, court costs and attorney fees.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment directly to (Charleston Neuropsychology / Gordon Teichner, Ph.D., ABPP) for services rendered, otherwise payable to me.

INSURED:_____ DATE:_____

Charleston Neuropsychology
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CONSENTS, POLICIES, AND PROCEDURES

Office Hours: By Appointment. Please give 24 hours notice for cancellations. The provider reserves the right to charge a fee for no shows or late cancellations, and these fees are not covered by insurance.

Service/Treatment: I agree to have A. Gordon Teichner, Ph.D. / Allison Adams, Psy.D. / Michael Sugarman, Ph.D. / or Cassidy Arnold, Ph.D. to perform psychological / neuropsychological testing, psychotherapy, and/or related mental health treatments, but I may at any time decline specific recommendations. I also agree to allow A. Gordon Teichner, Ph.D. / Allison Adams, Psy.D. / Michael Sugarman, Ph.D. / or Cassidy Arnold, Ph.D. to consult with other professionals deemed appropriate and necessary in providing quality care. South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners in Psychology. Board offices may be reached at: SC Board of Examiners in Psychology; PO Box 11329; Columbia, SC 29211-1329.

Signature:_____ Date: _____

Confidentiality: Information regarding treatment will not be released unless there is written consent; indication that immediate danger to self or others exists; a court order which directs the release of information; disclosure of sexual abuse, physical abuse and/or neglect of a child under the age of 18. If this evaluation is being conducted as part of legal proceedings, confidentiality may not apply, as information may be released to your attorney and may be discussed as part of a deposition and/or courtroom proceedings. I authorize A. Gordon Teichner, Ph.D. / Allison Adams, Psy.D. / Michael Sugarman, Ph.D. / or Cassidy Arnold, Ph.D. to release information regarding myself or my child to my insurance company and the professional who referred me. This information is protected under the Privacy Act. I have read the information stated above and am in agreement with the policies and procedures as presented.

Signature:_____ Date:_____

Fees: Fees and payment method will be discussed with you prior to or at your first visit. Payment is required in full at the time of each visit unless you can provide an "Explanation of Benefits" which shows that your deductible has been met or another payment system has been mutually reached. Co-payments are required at the time of service. You are encouraged to contact your insurance company to verify your coverage and determine the limits of your coverage. If your insurance company does not pay, you are responsible for payment in full.

I have read the information stated above and am in agreement with the policies and procedures as presented.

Signature_____Date:_____

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Acknowledgment of Receipt of Notice of HIPAA Privacy Practices

I acknowledge that I have received the HIPAA notice of Privacy Practices from Charleston Neuropsychology and/or A. Gordon Teichner, Ph.D., ABPP. This information is also available on our website.

Name of Patient or Personal Representative (Please Print): _____

Signature of Patient Or Personal Representative: _____

Date: _____

Adult Healthcare Consent Act (For Adult Patients Only)

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? ____YES ____NO

If YES, Name(s) of family member(s) or other individual(s): _____

You may revoke or modify an authorization with regard to any family member or other individual designated by yourself in the authorization, and that the revocation or modification must be in writing.

CHARLESTON NEUROPSYCHOLOGY - Office Policy

Our goal is to deliver the finest, most cost-effective psychological / neuropsychological care that is available. We will advise you of my recommendations for psychological / neuropsychological assessment and possible treatment options following your initial exam today. We will also discuss with you any out of pocket costs.

Payment for your care, including co-pays, deductibles, and non-covered services is due in full on the day of your clinic visit. Our office is happy to assist you by submitting your insurance claims. Based on information gathered from your insurance company, we will do our best to estimate what your insurance will pay for required assessment and treatment, and help you maximize your insurance benefits. Please note that this is an estimate. Like you, we are at the mercy of insurance companies and can only assume what they us is accurate; sometimes it is not. We encourage all patients to call their insurance company directly as well so that you are aware of your benefits, co-pays, co-insurance, and deductible to ensure that there are no surprises.

We accept cash, checks, debit cards, and most major credit cards. We do not offer payment plans.

Please understand that when our office schedules your appointment we are reserving time for your particular needs. We kindly ask that if you must change an appointment please give us at least 24 hours notice. This courtesy makes it possible to give your reserved time to another patient who would like it.

Our "No Show" and last minute cancellation (i.e., less than 24 hours notice) policies are as follows. There is a $75 charge for any missed 45-60 minute office appointments or cancellations with less than 24 hours notice. There is a $150 charge for missed psychological / neuropsychological testing sessions or cancelling testing with less than 24 hours notice. This charge is higher than a routine office visit as several hours of time is usually reserved for such examination. You, not your insurance, will be responsible for such fees. Repeated cancellations or missed appointments may result in loss of future appointment privileges.

Assignment of Benefits/Financial Responsibility

I assign all insurance benefits, if any, to Charleston Neuropsychology (Dr. Adams, Dr. Teichner, Dr. Sugarman, or Dr. Cassidy) for services rendered. I understand that I am ultimately responsible for all costs associated with charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize my provider to charge my credit card for the fees stated above if I no show for a scheduled clinic visit or cancel with less than 24 hours notice.

For divorced parents of children who are patients: The custodial parent is always legally responsible for the entire case fee without regard to divorce decree or any separate agreement may exist. There is no situation where splitting the case fee or making two financial arrangements for one case fee is acceptable or appropriate. Only one jointly custodial parent will be allowed to be accountable for the fee.

I have read and understand your Office Policy form.

_____

Signature (Patient or Parent) Relationship to patient if other than self

_____

Print Patient's Name Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Date(s) of Service Requested: _____

Information Requested: ____Medical Records_____

Purpose of Disclosure: _____Continuation of Care_____

I request and authorize ____Charleston Neuropsychology_____ to receive and release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I understand that this information may include reference to psychiatric care, sexual assault, alcohol abuse and/or drug abuse and results of tests for all infectious diseases including AIDS/HIV.
I understand that I have the right to revoke this authorization at any time by notifying the office in writing.
I understand that revocation will not apply to information that has already been released in response to this authorization.
I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I understand that authorizing the disclosure of this private health information is voluntary and that I can refuse to sign this authorization understand that I may inspect or obtain a copy of the information to be used or disclosed.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient, if signed Legal Guardian/Representative

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TELEHEALTH CONSENT FORM (Complete if requesting Telehealth Services)

Patient Name: _____ Date of Birth: _____

1. I understand that my psychologist would like me to engage in a telehealth appointment.
2. This appointment will use video conferencing technology using my computer or smartphone and will not be the same as an in-person visit due to the fact that I will not be in the same room as my psychologist.
3. I understand there are potential complications associated with this technology, including interruptions and technical difficulties. I understand that my psychologist or I can discontinue the appointment if the videoconferencing connection is not adequate for the situation or I am not comfortable with the technology.
4. Charleston Neuropsychology's telehealth services are operated through a third-party independent company known as doxy.me, which is compliant with all HIPAA-required confidentiality laws. I have the opportunity to review their policies at their website.
5. All the same rules and policies regarding patient confidentiality and protection of private information apply to telehealth as they would for in-person appointments at our clinic.
6. If there is a payment associated with my appointment, my provider may ask for my credit card information during the telehealth appointment.
7. If any questions or concerns regarding the use of this technology arise, I can feel free to directly ask my psychologist during the appointment.

By signing this form, I certify:

8. That I have read or had this form read and/or had this form explained to me.
9. That I fully understand its contents including the risks and benefits of telehealth.
10. That if I have any further questions about the technology, I will raise them with my provider during the appointment.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient, if Legal Guardian/Representative

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Credit Card on File Billing Authorization Form

Charleston Neuropsychology is offering a secure and convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential.

I,_____(print name), authorize **Charleston Neuropsychology / Gordon Teichner, Ph.D.** to capture my credit card information and securely store my credit card on file.

I authorize **Charleston Neuropsychology / Gordon Teichner, Ph.D.** to charge my credit card on file for any balance owing. This could be amounts resulting from balances related to co-payment, deductible, co-insurance, non-covered services, or denials for no coverage/eligibility but is not limited to these scenarios.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Patient Name: _____

Card Holder's Name (as shown on card): _____
☐ Visa ☐ Master Card ☐Discover ☐ American Express

Credit Card Number: _____
Expiration date (mm/yy):_____
Security code: _____

Email: _____

Cardholder's Signature: _____
Date: _____

* This form must be completed if you are requesting TELEHEALTH Services.