TNS

TRIANGLE NEUROPSYCHOLOGY SERVICES, PLLC
3310 Croasdaile Drive, Suite 400 Durham, NC 27705
1540 Sunday Drive, Suite 200 Raleigh, NC 27607

NEUROPSYCHOLOGICAL EVALUATION & TESTING

WHAT TO EXPECT:

Pediatric and Adult Neuropsychological evaluations are a 3-step process, meaning you will have 3 different appointments.

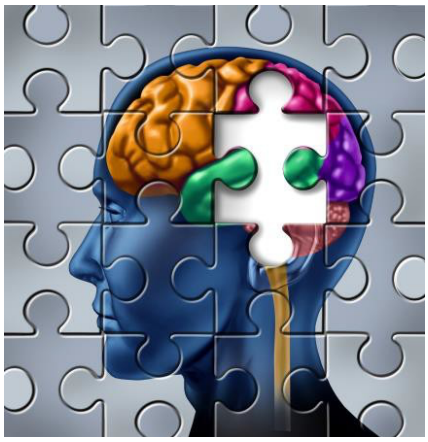
T**he first appointment will be an Intake Consultation** to review comprehensive medical history and details regarding your testing needs. The purpose of this is to determine which battery of tests would be appropriate for your situation as everyone is unique. This is done as a virtual telehealth visit via Zoom. The Intake will last approximately 1 hour with the doctor. At the end of this appointment, the doctor will schedule a date and time for your Testing and Feedback appointments.

The second appointment will be a Testing appointment in person at either our Durham or Raleigh office. This appointment will either be scheduled for an entire morning or entire afternoon and can last 3-5 hours. This appointment will be scheduled during your first Intake appointment. Because we are following strict CDC COVID guidelines, you will call us from your vehicle when you arrive for your appointment, and we will call you back when we are ready for you to enter our office.

We have 2 locations for testing:
Durham - 3310 Croasdaile Drive, Suite 400, Durham NC 27705 (adult and pediatric)
Raleigh - 1540 Sunday Drive, Suite 22, Raleigh, NC 27607 (adult only)

The third appointment will be a Feedback Session. This is also done as a virtual telehealth visit via Zoom to review the results of the testing. The Feedback will be scheduled NO LESS than 2 weeks after completing the testing.

Should you have any further questions, please feel free to call us at (919) 384-9682 or email us at info@triangleneuropsychology.com.



Triangle Neuropsychology Services
3310 Croasdaile Dr., Ste 400, Durham NC 27705
1540 Sunday Dr., Ste 200, Raleigh NC 27607
Phone: 919-384-9682
Fax: 919-384-9683

DEMOGRAPHICS

Patient Name: _____

Preferred Name or Nickname (if any): _____

Date of Birth: _____

Mobile Phone: _____

Home Phone: _____

Email Address: _____

Street Address: _____

City, State & Zip Code: _____

Referred By: _____

Gender at Birth (Required for Insurance): ○ Male ○ Female

If you prefer another gender term, please specify here: _____

Self-identified Race or Ethnicity: _____

Employment Status: ○ Full Time ○ Part Time ○ Student ○ Not Employed

Employer or School: _____

Occupation: _____

FINANCIAL

Name of Person Responsible for the Bill: _____

Relationship to Patient: _____

Contact Phone Number: _____

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person: ○ **YES** ○ **NO**

Name of Person to Contact in Case of Emergency: _____

Relationship to Patient: _____

Contact Phone Number: _____

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person: ○ **YES** ○ **NO**

Primary Insurance Company: _____

Subscriber ID: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Secondary Insurance Company (if any): _____

Subscriber ID: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Authorization Regarding Personal Health Information and Payment

- I hereby authorize Triangle Neuropsychology Services, PLLC to release medical information to insurance carriers and its agents concerning my illness and treatments. I authorize Triangle Neuropsychology Services, PLLC to use my email address for contact purposes only.
- I hereby authorize Triangle Neuropsychology Services, PLLC to release medical information in such cases, to my employer, if applicable for worker's compensation cases or other work-related medical cases.
- Unless otherwise restricted by applicable law, this authorization to release medical records includes the release of medical record information for all heath care services that previously have been or will in the future be provided by Triangle Neuropsychology Services, PLLC.
- I hereby authorize payments for medical services rendered to myself or authorize Medicare benefits, if applicable, to be made either to me or on my behalf to the above-named physician. I understand that I am responsible for any amount not covered by insurance. A photocopy of this authorization and assignments shall be considered as valid as the original.

Telehealth

Telehealth lets a doctor or other healthcare provider care for you, even when you cannot see him or her in person. The doctor uses the Internet or other technology to give you advice, give you an exam, or do a procedure through online communications. Telehealth can also be used to book an appointment or let your doctor talk with other providers about your health problem or treatment.

- Telehealth is more than a phone call, an email, a fax, or an online questionnaire. Sometimes you may need to come to a healthcare facility to use their equipment (TV screen, camera, or Internet). A provider may use need to use technology tools or medical devices to check on your health remotely. If you agree, part of your health record may be sent to the telehealth provider before your session.
- You and your healthcare team must decide if your health problem can be helped with telehealth. The team and others involved in your care (e.g., medical home or hospital teams) will make a plan for your care using telehealth. This will also include a plan in case you have an emergency during the telehealth session.
- If the patient is a minor child, the telehealth provider will explain to the parent how a telehealth exam is different from an in-person exam. He or she will also explain if a complete exam of the child is possible.

During your telehealth session:

- The provider and the staff will introduce themselves.
- The provider may talk to you about your health history, exams, x-rays, and other tests. Other providers may take part in this discussion.
- A visual and/or partial physical exam may take place. This may happen by video, audio, and/or or with other technology tools
- Non-medical staff may be in the room to help with the technology.
- Video and/or photo records may be taken, and audio recordings may be made.
- A report of the session will be placed in your medical record. You can get a copy from your provider.
- A main goal of telehealth is to make sure that you get good, personal health care, even though you are not seeing a provider in person.
- You will be told about all staff who will take part in the session. You can ask that any of these people leave the room to stop them from seeing or hearing the session. It is up to you to make sure the setting for your session is private. It should only include people who you are willing to share health information with. Your telehealth provider can ask that people with you leave the room to make sure your session is private.

Telehealth risks and common problems:

- If there is an equipment or Internet problem, your diagnosis or treatment could be delayed.
- Records or images that are taken and sent may be poor quality. This can delay or cause problems with your diagnosis or treatment.
- The records sent for review before the session may not be complete. If this happens, then it may be hard for the telehealth provider to use his or her best judgment about your health problem. For instance, you could react to a drug or have an allergic response if the provider does not have all the facts about your health.
- There could be problems with Internet security and privacy. For instance, hackers may access or view your health information. If this happens, then your medical records may not stay private.

Telehealth Patient Acknowledgment

By signing this form, you agree that you have read, understand, and agree with these terms. I also confirm by my signature below that I understand no guarantees have been made about success or outcome, and I agree to take part in a telehealth session.

PAYMENT AND INSURANCE

We do charge a fee of $50.00 for all missed telehealth appointments and a fee of $100.00 for all missed in-office testing appointments.

INSURANCE FILING AND COVERAGE

We will file your initial insurance claim(s) and provide documentation necessary for insurance reimbursement as a courtesy to our patients. We do not, however, guarantee that each service will be covered or what percentage will be covered. You may incur extra charges for refiling of insurance claims. Your co-pay and co-insurance may be determined before your visit and is expected at time of service.

Please call your insurance company and provide the following codes so that they can check your eligibility, the projected copay, coinsurance, deductible, and non-covered services amounts that you may be assessed after insurance adjudication.

These CPT codes are:

- **96116**
- **90791**
- **96121**
- **96136**
- **96137**
- **96138**
- **96139**
- **96132**
- **96133**

Procedure Notice:

Testing includes time for the selection of tests, the administration of tests, the scoring of tests, and the interpretation of tests. The discussion of testing results will be done during the Feedback session. In certain cases, a more comprehensive and time-consuming assessment may be needed. This would be regarding such cases, but not limited to, medicolegal cases. If a more comprehensive assessment is needed, it may or may not be completely covered by an insurance plan. The responsible party as noted below accepts responsibility for these charges. If you have any questions, please speak with our Practice Manager. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

Payment:

In the event your insurance does not cover our services (or any portion thereof, we will work with you regarding payment. Unless we agree otherwise, we expect full payment within thirty (30) days of the date of service. You bear ultimate financial responsibility for all services rendered to you, including worker's compensation claims and personal injury cases, regardless of the outcome of litigation. If coverage is denied under worker's compensation, you will pay any unpaid balance, notwithstanding any appeal of such denial. With respect to personal injury cases, you are responsible for fees incurred, we may not be able to seek payment from third parties, and we cannot wait on the outcome of pending litigation for payment. We do not accept contingency fee arrangements. If there is any remaining balance(s) due at the time of settlement, you hereby authorize your attorney to clear your outstanding accounts. Your signature also constitutes your irrevocable agreement to a waiver permitting payment of health insurance claims directly to Triangle Neuropsychology Services, PLLC prior to claimant receiving such funds.

Guarantee of payment and assignment of insurance benefits:

For value received, the undersigned guarantor and/or patient (hereinafter "the Undersigned") promises to pay to Triangle Neuropsychology Services, PLLC (hereinafter "Provider") all charges incurred for services rendered to the Undersigned. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by Provider in the event insurance does not pay for these services. It is acknowledged that the ultimate completing and following up of any insurance claims is the responsibility of the Undersigned. It is further agreed by the Undersigned that if, in the event any monies received by the provider from the insurance carrier are at any time after their receipt withdrawn from the Provider by the insurance carrier, the Undersigned will be responsible for those monies then due and owing and waives any defense for payment the Undersigned may have against Provider. In the event this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs but including responsible attorney fees. The undersigned authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized.

Forensic cases:

Responding to discovery requests, conferences, and phone calls with attorneys involves additional time and record-keeping. Additionally, Patient (or Responsible Party) is responsible for all direct

costs and expense associated with Triangle Neuropsychology Services, PLLC and its attorney representative in matters responding to discovery requests (including depositions) and with these conferences including, but not limited to, court appearances, preparation of reports, photocopying, phone calls, faxes, long distance travel, overnight delivery, and courier services. These expenses are billed to Patient (or Responsible Party) and to patient's attorney. Patient (or Responsible Party); however, remain primarily responsible for payment of these charges if not paid in full within 60 days.

PRIVACY POLICY

Purpose:

This practice applies the Health Insurance Portability and Accountability Act (HIPAA) to protect the privacy of personal healthy information and to provide secure storage of such information. This is information that relates to the past, present, and/or future physical or mental health condition of a patient. This includes information that relates to the past, present, and/or future health care that is provided to a patient. This includes personal information that could reasonably be used to identify a patient. This includes all information transmitted in any medium.

Right to privacy/confidentiality:

All communication between the patient and the doctor and/or social worker becomes part of the clinical record. Records are the property of Triangle Neuropsychology Services, PLLC. In accordance with legal requirements, the patient records are shredded and disposed of after seven years. While most communication between the patient and the doctor and/or social worker is confidential, the following limitations and exceptions do exist:

- The doctor and/or social worker determines that the patient is a danger to himself/herself or someone else.
- The patient discloses abuse, neglect, or exploitation of a child, elderly, or disabled person.
- The patient authorizes the doctor and/or social worker to release records.
- The referral source requests the release of records.
- The patient has a medical emergency while at this practice.
- The doctor and/or social worker is mandated to disclose information. [This includes authorization under the HIPAA Privacy Rule Section 164.512 when disclosure is mandated by law enforcement agencies, to a coroner or medical examiner, by Public Health offices relating to diseases or FDA-regulated products, for specialized government functions (such as fitness for military duty, VA benefits, and/or national security issues), or to a health oversight

committee (such as the US Department of Health and Human Services or a state department of health).]

Your rights regarding personal health information:

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Practice Manager.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained clinic notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- Right to Amend. If you feel that the PHI, we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Practice Manager if you have any questions.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Confidential Communication. Normally, we send information related to your healthcare to the address and phone numbers you have provided. However, you have the right to request that your healthcare information be to an alternative address to protect confidentiality. You may do so by completing our form to request confidential communication.

Breach notification:

This practice conducts quarterly assessments to keep office policies in line with the privacy and security specifications as defined by HIPAA and the American Psychological Association. If the practice becomes aware or suspects a breach of patient information, the practice will conduct a risk assessment and keep a written record of that risk assessment. Unless the practice determines that there is a low probability that personal health information has been compromised, the practice will give notice of the breach. In the event of a breach, the practice will re-assess its privacy and security practices to determine what changes should be made to prevent the recurrence of such breaches.

EMERGENCIES

During office hours, the patient can contact the doctor on the office phone: 919-384-9682. In the event of an emergency that is not during office hours, the patient may call the office phone and receive further contact information through their doctor's voicemail. If the patient is unable to reach his/her doctor in a timely manner, the patient should contact his/her primary care physician, a local emergency room, or a local police department when necessary. Also, the patient may contact a local 24-hour help-line (numbers listed below). It is the patient's responsibility to seek the appropriate resources in emergency situations.

DURHAM CRISIS RESPONSE CENTER

(24-hour referral and assistance) – 919-403-6562

WAKE COUNTY ALLIANCE BEHAVIORAL HEALTH

(24-hour referral and assistance) – 800-510-9132

ORANGE COUNTY CRISIS RESPONSE CENTER

(24-hour referral and assistance) – 919-732-5063

CURRENT MEDICATIONS LIST

Primary Care Physician Name: _____

Practice Information: _____

Drug Allergies: _____

LIST OF CURRENT MEDICATIONS

Please list all prescription medications, non-prescription medications, vitamins, supplements, and herbals. Please list medication that is taken daily and medication that is taken occasionally. Also you are responsible for advising Triangle Neuropsychology Services, PLLC of any changes to these medications.

Name of Medication	Dosage	Frequency	Reason	Comments

PERMISSION TO RELEASE INFORMATION

If you would like our office to be able to speak to a friend or family member, either with you present or without you present, please list below. Also list the name and practice name of any medical professionals you would like us to send your final feedback report to, if any. We will always send the feedback report to your referring physician as well.

Name of Person: ____

Relationship to Patient: ____

Contact Phone Number: ____

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person WITH ME PRESENT: ○ **YES** ○ **NO**

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person WITHOUT ME PRESENT: ○ **YES** ○ **NO**

Name of Person: ____

Relationship to Patient: ____

Contact Phone Number: ____

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person WITH ME PRESENT: ○ **YES** ○ **NO**

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person WITHOUT ME PRESENT: ○ **YES** ○ **NO**

Name of Person: ____

Relationship to Patient: ____

Contact Phone Number: ____

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person WITH ME PRESENT: ○ **YES** ○ **NO**

I authorize/allow Triangle Neuropsychology Services, PLLC to discuss my medical information with this person WITHOUT ME PRESENT: ○ **YES** ○ **NO**

QUESTIONNAIRE FORM FOR TRIANGLE NEUROPSYCHOLOGY SERVICES

Patient Name: _____

Patient DOB: _____

Name of Person Filling Out This Form: _____

Relationship to Patient: _____

Please briefly describe the concern(s) you have about the patient's thinking?

_____

_____

_____

_____

What do you hope to learn from the neuropsychological evaluation?

_____

_____

_____

_____

What do you hope to learn from the neuropsychological evaluation?

_____

_____

_____

_____

_____

Physical Changes

Please indicate:	**YES**	**NO**	**DON'T KNOW**
Have you noticed any changes in the patient's ability to walk?			
Have you noticed any changes in the patient's ability to use their hands (e.g., use a pen or fork) or have they become uncoordinated (e.g., dropping items)?			
Have you noticed any trembling (i.e., shaking/quivering) in the patient's hands, legs, neck, or voice box?			
Does the patient appear to act out dreams and/or has the patient fallen out of bed?			
Does the patient punch or kick in their sleep?			
Does the patient appear to have periods of daytime drowsiness, confusion/staring into space, or disorganized speech?			
Does the patient have trouble making it to the bathroom on time or having to rush to the bathroom?			
Has the patient been sweating more than usual or experiencing rapid changes in temperature?			
Does the patient move slower?			
Has the patient had any changes to their ability to smell?			
For men: Does the patient experience erectile dysfunction?			
Does the patient ever see or hear things that are not there? For example, have they mentioned seeing people, animals, or objects that are not there or that other people cannot see?			
Has the patient had any changes to their mood? For example, are they more irritable, less interested in things that they used to like, angry, or happy?			

Functional Abilities

As a result of the THINKING CHANGES (not physical changes) does the patient have difficulty…	**YES**	**NO**	**DON'T KNOW**
Using the toilet?			
Bathing?			
Getting dressed?			

Grooming? (e.g., shaving, combing hair)			
Eating/drinking?			
Driving? (i.e., do they get lost while driving? Recent accidents or tickets? Running red lights or stop signs?)			
Remembering to take medication as prescribed?			
Making and keeping appointments?			
Taking care of household/outdoor chores?			
Managing finances?			
Are there any activities that the patient cannot do alone because of thinking changes?			
If still working, have other people noticed that the patient is having difficulty?			

Please indicate:	**YES**	**NO**	**DON'T KNOW**
Does the patient have difficulty falling asleep?			
Does the patient have difficulty staying asleep?			
Does the patient have difficulty getting up in the morning?			
Is the patient tired during the day?			
Does the patient snore?			
Has any doctor ever told the patient that they have sleep apnea?			
Does the patient nap?			
Does the patient experience any regular pain?			

Please indicate:	**YES**	**NO**	**DON'T KNOW**
Has the patient ever had a stroke?			
Has the patient ever had a seizure?			

Has the patient ever hit their head hard?			
Has the patient had any recent falls?			
Has the patient had any hospitalization in the past year?			
Has the patient noticed any changes to their vision or hearing?			
Does the patient wear hearing aids?			

Please indicate:	**YES**	**NO**	**DON'T KNOW**
Has the patient ever been diagnosed with mental health difficulties (depression, anxiety, post-traumatic stress disorder, bipolar disorder, etc.)?			
Has the patient ever taken medication for their mood or for other psychological reasons?			
Has the patient ever spoken to a counselor, therapist, or psychologist?			
Has the patient had any changes to their appetite in the past year?			
Has the patient had any changes to their food preferences in the past year? For example, increased desire for sweet food?			
Does the patient drink alcohol?			
Has the patient ever had a period of overusing recreational drugs?			
Has the patient ever been a regular tobacco/nicotine user?			
Has the patient ever had problems in their life from drinking or using recreational drugs? For example, DUIs, relationship problems, problems at work, went to rehab, etc.?			

Please indicate: As far as you know…	**YES**	**NO**	**DON'T KNOW**
Did the patient's mother have any complications with the patient's pregnancy?			
Were there complications with the patient's birth?			
Did the patient walk on time and talk on time?			
Did the patient have any significant illnesses or injuries as a child?			

Did the patient have behavioral problems as a child? For example, were they frequently in trouble or getting into fights?			
Did the patient have trouble learning while they were in school?			
Were they ever diagnosed with an attentional disorder or a learning disorder?			
Did the patient skip a grade or get held back?			
Did the patient finish high school?			
Did the patient start a college or technical program?			
Did the patient obtain a college degree? (Associates, bachelor's, master's, or doctorate)?			
Is the patient a Veteran?			

Please indicate…	**YES**	**NO**	**DON'T KNOW**
Is the patient currently involved in any form of litigation?			
Is the patient currently seeking any form of financial compensation (i.e., workers compensation, disability, service-connection, etc.)?			
Does the patient have a financial or medical power of attorney (POA) or a legal guardian?			
Is anyone in the process of seeking POA or guardianship for the patient?			

FINAL PAGE FOR SIGNATURE

If you are signing this form on behalf of the Patient, you must state your relationship to the patient. If you are the Health Care Power of Attorney for a Patient, you must provide legal documentation to this effect. If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, legal guardian, or other person acting loco parentis who has the authority to act on the minor-Patient's behalf. By signing this form for someone else, you as the parent, legal guardian, a party acting as loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

_____

Signature of Patient or Legal Representative

_____

Written Name of Patient or Legal Representative

Signature Date: _____

Relationship to Patient: _____