CNS MEMORY CLINIC

Comprehensive Neuropsychological Services

PEAK PERFORMANCE INSTITUTE

UPGRADE YOUR BRAIN

CNS/Adults Phone (623) 977-6860 • 2440 N. Litchfield Road, Suite 200 • www.cnsmemoryclinic.com
PPI/Children Phone (623) 440-5053 • 2440 N. Litchfield Road, Suite 206 • www.peakperformancebrain.com

Today's Date _____

Patient Name _____ **Birthdate** _____
First Name, Middle Initial, Last Name

Current Age _____ **Male / Female** _____ **Marital Status** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____

Race/Ethnicity _____ **Language Spoken at Home** _____

If patient is a minor (under 18): **Parent/Guardian** _____

E-mail _____

Name of Policyholder _____ **Birthdate** _____

Social Security # (billing purposes) _____

Emergency Contact _____ **Phone #** _____

Primary Care Physician's Name _____

Primary Care Physician's Phone # _____

Neurologist or Referring Doctor's Name _____

Neurologist or Referring Doctor's Phone # _____

What are your major complaints and/or symptoms? _____

_____

_____

_____

_____

If automobile accident/injury/stroke, please indicate date and lawyer's name (if any):

_____

Comprehensive Assessment of: Memory Loss – Mild Cognitive Impairment (MCI) – Alzheimer's Disease – Dementias (e.g., Vascular) – Postconcussional Syndrome (PCS) – Traumatic Brain Injury (TBI) – Transient Ischemic Attack (TIA) – Stroke & Recovery – Competency Evaluations – Neurodegenerative Disease (e.g., ALS, Multiple Sclerosis, Parkinson's) – Forensic Evaluations – Attention Deficit Disorder (ADD) – Intelligence (IQ) Testing & Learning Disorders (e.g., Dyslexia, Dysgraphia, Reading and Math Learning Disorders – Autism Spectrum Evaluations – Selective Mutism – Conduct and Oppositional Defiant Disorder – Anxiety, Depression, Bipolar, OCD, PTSD, and other Psychological Assessments – Post COVID-19 Cognitive Loss – Surgical Candidates (e.g., SCS, gastric)

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ASSIGNMENT AND RELEASE FORM FOR NEUROPSYCHOLOGICAL EVALUATION: INCLUDING INITIAL INTERVIEW, TESTING, AND FOLLOW-UP (TEST RESULTS) APPOINTMENTS

1. I hereby assign my insurance to be paid directly to CNS Memory Clinic LLC, doing business as (dba) Comprehensive Neuropsychological Services (CNS) as well as Peak Performance Institute (PPI).

2. I am aware that insurance approval for my visits is not a guarantee of payment and I agree to be financially liable for all charges that may occur.

3. Further, I understand that I am responsible for any co-pay, coinsurance, deductible, non-covered or not deemed medical necessary service.

4. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect the collection of this indebtedness.

5. I understand that it is my choice to continue with this office appointment.

6. I also authorize Dr. Dane A. Higgins and his medical assistants to release pertinent health information required by my insurance plan for the purpose of filing my medical health care or behavioral health care claim in order to make every effort to collect for services rendered.

_____	_____
Patient Name (printed)	Parent/Guardian Name (printed)
_____	_____
Date	Patient/Guardian signature

CNS Memory Clinic LLC

DBA: Peak Performance Institute

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out Treatment, Payment or Health Care Operations and for other purposes that are permitted by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Your health record is the physical property of the healthcare practitioner or facility that collected it but the information belongs to you. You can inspect, read, or review it. If you want a copy of the report or records, the office has the right to charge you for the service. Exceptions include examinations for the purpose of criminal or personal injury litigation, independent medical or neuropsychological examinations (IME), disability determination or court ordered examinations. For example, in IME situations, the referring insurance company, attorney, employer or other payer holds the privilege to determine what information is to be released and to whom it shall be released to. In these and other situations, the examinee cannot authorize the release of information obtained in the process of examination or consultation. Applicable law states that individuals do NOT have the right to information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action of procedure. (45 CFR 164 (a) (1)

Uses and Disclosures of PHI: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. At no time will any information of any kind relating to any of our patients be discussed outside of this office unless permitted or required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your PHI as necessary to contact you to remind you of your appointment.

We are also permitted to use or disclose your PHI without your written authorization for certain purposes: As Required By Law, Public Health Activities (e.g. preventing the spread of disease), Health Oversight Activities, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement Purposes, Coroners, Funeral Directors and Organ Donation, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates.

Your Rights: Following is a statement of your rights with respect to your PHI:

You have the right to inspect and copy your PHI. If we use or maintain an electronic health record for you, you may get that information in electronic format and ask us to send it to a person or organization that you identify. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, neuropsychological testing RAW DATA, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction on the use or disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of Treatment, Payment or Health Care Operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We will consider your request, but in most cases are not legally obligated to agree to those restrictions (e.g., if your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted, but you then have the right to use another Healthcare Provider). However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the PHI pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. Your request for an accounting must be submitted in writing. If we use or maintain an electronic health record for you, you may get a list of the disclosures we have made, if any, of your electronic health record for three years prior to the date of your request. For accountings that do not include disclosures made through an electronic health record, the request may not cover a time period longer than six years from the date of the request.

You have the right to be notified of a breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively *i.e.* electronically.

This notice was published and becomes effective on/or before July 1, 2021. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice. You can also request a copy of this notice at any time.

Complaints You may complain to us or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of PHI and to provide individuals with this notice of our legal duties and privacy practices with respect to PHI

Signature below is acknowledgment that you have read and understand our Privacy Practices.

Patient Name: _____ **DOB**: _____

Patient/Legal Guardian Signature: _____ **Date**: _____

Release of Information

I _____ hereby authorize CNS/PPI to release or discuss all information pertaining to myself or my medical records with the following people.

Name: _____Relationship: _____Phone Number: _____

Name: _____Relationship: _____Phone Number: _____

Name: _____Relationship: _____Phone Number: _____

I authorize CNS/PPI to contact me at:

Cell Phone: _____ Home Phone: _____

May we leave a message or text? ☐ Yes ☐ No

Patient/Legal Guardian Signature: _____ Date: _____

Please list all medical providers that you would like the report to be released to:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____