Dana Group Associates

220 Reservoir Street, Suite 21
Needham, MA 02492-2502

781-449-1143
Fax: 781-449-5992

FOR DGA INTERNAL USE: **MEDfx #** **SYSTEM DATE**

Client Registration Form

Client Information **Date of 1ST Appointment:**

Name _____ Date of Birth _____
Soc Sec # _____ Sex M - F Age _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Occupation _____ Employer _____
Email _____

Responsible Party For All Payments Due for Client Services

Name _____ Relationship to Client _____
(If different than above)
Marital Status: _____ Child Custodial Status _____
Address _____
Telephone(s) _____
Signature _____

Home Contact Information

Name _____ Phone _____
Address: _____ Cell Phone _____

Emergency Information

Contact Name _____ Phone _____
Specifics _____

Referred by _____ **Primary Care Physician** _____

Family Members/Others Living in Home

Name	Relationship to Client	Date of Birth	Occupation/School

Insurance Information: Copy of both sides of Client's Insurance Card Required-
Subscribers Full Name: _____ **DOB:** _____

FOR DGA INTERNAL USE

Clinician _____ CPT Code: 90801 Initial Intake Date _____

Diagnosis at Intake
Axis I _____ _____
Axis II _____ _____
Axis III _____ _____
Axis IV _____ _____
Axis V _____ _____

PLEASE FILL OUT BOTH SIDES OF SHEET

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www.dana-group.com

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

SIGNATURE PAGE

This form is an agreement between you _____ and Dana Group Associates. When we use the word "you" below it will mean your child, relative, or other person if you have written his name here.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing that you have read and understand our Notice of Privacy Policies and you are agreeing to let us use your information here and send it to others in accordance with our written policies. Please make sure you have read and understand our Privacy Policies above before signing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Policies, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Policies. If we do change it, you can get a copy from our website: www.dana-group.com or by calling us at 781-449-1143 x300.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or personal representative

Printed name of client or personal representative

_____ _____

Date of Signature

Date DGA received by client or representative

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FINANCIAL POLICIES AGREEMENT

Payment for services provided by Dana Group Associates is due at the time services are rendered unless payment by health insurance has been arranged prior to the visit. If insurance coverage has been arranged, payment of any applicable copayment or deductible is due at the time services are rendered. If we do not have a contractual provider relationship with your insurance plan, full payment for services is due at the time services are provided. We will bill your insurance for you, and reimburse you if we receive payment. You agree to be fully responsible for payment for all services not covered by your insurance. I there is a problem with your insurance coverage, you agree to pay your bill and deal with your insurance company yourself. As a courtesy to you, we will attempt to verify your insurance coverage and determine and determine your insurance benefits. However, if your insurance company has misinformed us or you feel we have misinformed or failed to adequately inform you regarding your benefits, you are still responsible for payment of all charges not covered by your insurance. We encourage you to verify your insurance benefits and coverage yourself and make sure that you fully understand your coverage. By signing this agreement you agree to responsible for all charges for the client identified below, even if you believe that some other party should bear responsibility for these charges. **Some services may not be covered by health insurance.** You agree to be fully responsible for payment for all services that are not covered by the health insurance plan. This may include charges for telephone consultation, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals attorneys, courts, agencies, or others. Limited telephone consultation is part of routine patient care and is undertaken without charge. However, when extensive telephone consultation or other than routine written correspondence or reports are requested or required, a charge for these services will be applied. If these charges are excluded from coverage by health insurance plan, they will be your responsibility. Every effort will be made to notify you if such charge is likely to occur. However, the exact amount charged cannot always be predicted in advance.

When an appointment is missed or canceled without at least 24 hour prior notification a $100 fee for the cancelled appoint will be charged. Fees charged for missed appointments or late cancellations must be paid prior to the next appointment. A service charge of 1.5 % of the outstanding balance or a minimum of $5.00 will be added each 30 day billing cycle to all outstanding balances over 60 days past due. A charge of $25.00 will be applied for all checks returned unpaid. If an overdue account is sent to a collection agency, collection fees and expenses will be added to the amount due. A copy of the current applicable fee schedule of Dana Group Associates is available upon request. Fees may be modified without notice.

ACKNOWLEDGEMENT AND AGREEMENT

I have read the above and affirm that everything in this form that was not clear to me has been explained to my satisfaction. I understand that it is my responsibility to know my insurance benefits. I hereby agree to abide by the policies specified above and to be responsible for all fees and charges for services provided by Dana Group Associates to or on behalf of the client named below. This agreement will continue as long as Dana Group Associates provides services or until written request that this agreement be terminated is received by Dana Group Associates.

Assignment of Health Insurance Benefits: This signature below authorizes payment directly to Dana Group Associates of benefits under health insurance policy covering the client named below. A photo copy of this form is considered as valid as the original. For Medicare Clients only: The undersigned hereby requests that payment of authorized benefits be made to Dana Group Associates on behalf of the client named below. The undersigned authorizes any holder of medical information about the client to release the Health Care Financing Administration and its agents any information needed to determine those benefits payable for related services.

Signature of Client	Name of Client	Date
Signature of Responsible Party	Name of Responsible Party, Printed	Date

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TESTING FEE SCHEDULE

Testing Insurance Authorizations and Payment

Some testing services require prior authorization from your insurance carrier and/or your Primary Care Physician; however, some or a portion of the services may only be partially covered or not covered at all. When fees are partially or not covered, payment for these testing fees not covered is due at the time Initial Visit.

The Initial Evaluation Interview and Diagnostic Feedback Sessions will be billed separately to your Insurance Company in accordance with our Clinical Services Fee Schedule.

Payment Plans for Private Self-Pay Clients

For Self-Pay Clients wishing a Payment Plan, a Valid Credit Card Authorization must remain on file in the Business Office to be applied to the payments when due.

For Testing Fees ranging from $3,150 – $2,100, the payments can be made in three equal installments; due and payable at the time of Initial Visit, Initial Testing Session and the Diagnostic Feedback Visit.

For Testing Fees ranging from $2,000 and less, the payments can be made in two equal installments; due and payable at the Initial Visit and the Diagnostic Feedback Visit.

Most Requested Testing Services and Fees

The stated fees include the following services:

- **All face to face testing**
- **Review of records**
- **Scoring and interpretation of tests**
- **Written report of test results and recommendations**

Tests administered may vary depending on diagnostic issues and objectives. All testing fees are determined and billed in hourly units of $175 for each unit.

Type of Testing	Tests Administered/Abilities Assessed		Fee
Comprehensive Neuropsychological Evaluation Approximately 18 Units of Testing	Includes:	Neuropsychological Evaluation Personality Behavioral Intelligence Educational	3,150.00
Neuropsychological Evaluation Approximately 12 Units of Testing	Includes:	Assessments as needed of Intelligence Perceptual/Motor Skill Attention Disorder Executive Functioning	2,100.00
Comprehensive Psychological Battery Approximately 14 Units of Testing	Includes:	Intelligence Educational Personality Behavioral	2,450.00

Most Requested Testing Services and Fees, continued

Type of Testing	Tests Administered/Abilities Assessed		Fee
Full Cognitive/Learning Evaluation Approximately 14 Units of Testing	Includes:	Neuropsychological Intelligence Educational	2,450.00
Full Cognitive Battery Approximately 12 Units of Testing	Includes:	Neuropsychological Intelligence	2,100.00
Learning Disabilities Evaluation Approximately 8 Units of Testing	Includes:	Intelligence Educational	1,400.00
Personality Approximately 8 Units of Testing	Includes:	Rorschach Story Telling (Roberts, TAT, CAT, TED, etc.) Figure Drawings (DAP, KFD, HTP) Sentence Completion Depression Inventory, Anxiety Scale, etc. as needed	1,400.00
Educational Approximately 5 Units of Testing	Includes:	Wechsler Individual Achievement Test or Woodcock-Johnson Achievement Battery and/or WRAT-3, Stanford, etc. Auditory/Visual/Motor/Language Assessment	875.00
Sage School Admissions Testing Approximately 4 Units of Testing	Includes:	School Required Testing & Reports	700.00
ADHD Approximately 4 Units of Testing	Includes:	Assessments of Attention, Memory, Executive functions Social-Emotional functioning Peer Relations Behavioral functioning	700.00
Intelligence Approximately 4 Units of Testing	Includes:	Wechsler Scale (WISC-III or WPPSI-R or WAIS III)	700.00
Kindergarten Screening Approximately 4 Units of Testing	Includes:	WPPSI-R Subtests Figure Drawings VMI-4 Color/Number/Letter Recognition Parent Interview Child Play Interview Behavioral Checklists	700.00
Behavioral Approximately 3 Units of Testing	Includes:	Behavior Rating Scales Diagnostic Checklists as needed Self-Report Checklists as needed	525.00** **No Charge if part of a larger evaluation

Additional Testing - Clinical Services

When evaluations require additional tests to those listed above or different combinations than those listed, fees will be discussed with the client and/or family in advance.

Written test reports will be provided between four (4) to six (6) weeks following the completion of testing. These are generally provided to the parents and/or school after a diagnostic feedback session with the parents and/or child.

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Testing Services Agreement

Testing Services For: _____

Testing Services: _____

Testing Units Required: _____ **Units @ $175** **Total Testing Fee:** _____

There are very few insurance companies that will authorize psychological or neuropsychological testing based on their assessment of what is reasonable and necessary. This depends on the nature of the problem, the specific diagnosis, and the severity of the problem. Denial of the testing authorization for the full number of testing units required may be due to several reasons. Most insurance companies, for example, will deny testing for learning disabilities because they believe that the school district in which the child lives should fully or partially conduct such an assessment.

Although we will make every reasonable effort to obtain authorization from your insurance company on your behalf, it is possible that they could deny coverage:

- **Prior to Approved Authorization:** If you believe that your insurance company will authorize payment and you wish to pursue testing services before the authorization is determined, your signature below stipulates your agreement to take full responsibility for the payment of these testing services in advance of the authorization.

- **Partial Insurance Benefit:** If your insurance company authorizes a limited number of testing units to perform the testing services required, your signature below stipulates your agreement to be personally and fully responsible for the full payment at time of testing for the number of testing units not authorized by your insurance provider.

- **Self Payment Plan:** If the insurance company denies coverage, and you wish to pay for the testing for your child or self, this will then be treated as a Self-Pay Case. With Self-Pay, the full payment is due and payable at the Initial Visit with the clinician. If, after the Initial Visit, it is determined that testing is not required, the full payment will be refunded, less the Initial Visit fee of $200.
  If you wish to participate in a Payment Plan, a Valid Credit Card Authorization (reverse side) must be completed and remain on file in the Business Office throughout the duration of the payment plan, to be applied to the payments when due.
  The schedule for installment payments are based on the total amount due and identified below. Your signature below stipulates your agreement to be personally and fully responsible for the full payment.

Authorized Agreement **Date:** _____

In the event of insurance full or partial denial for testing units coverage authorization, I agree to be personally and fully responsible for the non-insured testing fee indicated by Dana Group Associates.

Election Options

A. Payment in Full at Initial Visit

B. Payment Plan: Two Equal Payments ($2,000 & Less)
- **$_____ due at Initial Visit**
- **$_____ due at Diagnostic Feedback Visit**

C. Payment Plan: Three Equal Payments ($3,150 – $2,100)
- **$_____ due at Initial Visit**
- **$_____ due at Initial Testing Visit**
- **$_____ due at Diagnostic Feedback Visit**

_____ _____

Responsible Party Name **Responsible Party Signature**

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Please Print All Information Requested

VISA/MASTERCARD AUTHORIZATION & PROCESSING FORM

I, _____ authorize Dana Group Associates
(Cardholder)
to submit charges for services rendered for myself and family members to my (Circle One)
VISA **MASTERCARD**

CARD NUMBER (16 digits): _____ _____ _____ _____

EXPIRATION DATE (Month/Year): _____

V-Code (3 digits on reverse side of card): _____

Street Number & Name of Credit Card Billing Statement Address:

_____ _____
(Number) (Street Name)

City & Zip Code of Credit Card Billing Statement:

_____ _____
(City) (Zip Code)

I understand that charges can be submitted weekly, semi-monthly or monthly. This authorization will be in effect until I notify Dana Group Associates in writing to discontinue the use of this card.

_____ _____
(Date) (Cardholder Signature)

FOR OFFICE USE ONLY

CLINICIAN(S) _____

CLIENT NAME:_____

_____ **TESTING** _____**GROUP** _____**INDIVIDUAL** **MEDfx #**_____