ROCKY MOUNTAIN
Memory Center
Kathleen A. Lauren, Ed.D.
Clinical Director • Clinical Neuropsychologist • Adult and Geriatric Neuropsychology

# Out of Pocket Costs for Evaluation with Rocky Mountain Memory Center

**Patient:**

**DOB:**

| | |
|---|---|
| **Primary Insurance:**<br>**Member ID:**<br>**Benefits:**<br>**Deductible**<br>**Co-pay -** | **Secondary Insurance: None**<br>**Member ID:**<br>**Benefits:** |

**Patients should call your insurance company and check on benefits for evaluation services**. It is essential that you understand your contract benefits for requested services before attending an evaluation. Anticipated Out-of-Pocket costs are based on our communication with your insurance company to pay to Medicare guidelines. RMMC will not enter into a dispute with the Undersigned insurance company over any claim, although the Provider will submit necessary documentation the Undersigned insurance company requests to sort out any confusion or questions that may arise. Payments not covered by insurer are patient's responsibility to RMMC.

**Anticipated Out of Pocket Cost: $0.00**

Although no prior authorization is needed, your insurance requires a $__ co-pay per visit. Anticipated cost is estimated on interview, 2 days of evaluation and feedback. However evaluation may require additional time dependent upon the needs of the patient.

**$ 0.00 due at Interview**

**$0.00 due at time of Feedback, additional costs may be incurred if additional dates of service or codes are required for testing.**

Rocky Mountain Memory Center bases out of pocket costs on information provided to our office through your insurance company. We do NOT guarantee that out of pocket cost estimates will be accurate, it can depend on how your insurance company processes the claim once it is received. If you would like to contact your insurance company to confirm the above benefits, check for coverage of the following codes and diagnoses:

| | | |
|---|---|---|
| 96116 | 96121 | 96156 |
| 96130 | 96133 | |
| 96131 | 96138 | |
| 96132 | 96139 | |

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**Date:**

**Patient Name:** **DOB:**

**RE: Neuropsychological Evaluation**

Thank you for referring the above individual to Rocky Mountain Memory Center (RMMC) for neuropsychological evaluation. We appreciate you entrusting RMMC with the care of this patient. In order for us to proceed with the evaluation, we will need you to complete and sign the following forms:

| | | |
|---|---|---|
| 1. | New Patient Registration Form | X |
| 2. | Reason for Referral Form | X |
| 3. | Authorization to Release Information to Dr. Lauren Form | X |
| 4. | Notice of Privacy Practices for Protected Health Information Form. | X |
| 5. | Consent for Neuropsychological Evaluation Form | X |
| 6. | Guarantee of Payment and Assignment of Insurance Benefits Agreement | X |

**Payment and Office Policies**

**Please be advised that my administrative assistant, Kate will be processing your referral.** Once you have returned requested information to Kate, she will begin processing your referral. Questions concerning changes to appointments, last minute cancellations or unexpected delays are most efficiently handled by calling Kate at 970 221-1073.

**Patients should call your insurance company and check on benefits for evaluation services**. It is essential that you understand your contract benefits for requested services before scheduling an appointment.

**The billing agent at RMMC is Suzie. She can be reached at 970-419-0999.** Suzie will be glad to work with you in determining potential out of pocket expenses not covered by your insurance company, including co pays and coinsurance amounts. RMMC will attempt to verify what additional expenses will be *prior to* the evaluation; however this is *an estimate* and may not reflect final charges.

***PLEASE NOTE:*** The patient MUST agree to complete the evaluation as indicated by *their* signature on the Consent for the Neuropsychological Evaluation form. The Medical Power of Attorney may sign for the patient on the Privacy Practices Statement, the Clinic Polices and the Authorization to Release Information. In addition the guardian or the Durable Power of Attorney may sign for the patient on the Clinic Fee Schedule.

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Adult and Geriatric Neuropsychology

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**Registration Form**

Instructions: Please complete all sections. Write "same" if information is contained in, or the same as, previous sections.

Pt. Name: _____ DOB: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Patient SS#: _____ Cell Phone: _____

Patient Email: _____

Family Member Information: (Name & Phone number of nearest relative): _____

Referring Doctor: _____ Referring Doctor Phone: _____

Referring Doctor Address: _____ Referring Doctor Fax: _____

Primary Care Doctor: _____ Primary Care Doctor Phone: _____

**Responsible Party**

Name: _____ Relationship: _____ DMPOA: _____

Address: _____ Phone: _____ Fax: _____

Employer: _____ Email: _____

**Insurance Information** **Primary Insurance:** _____ Policy #:_____

Address: _____ Phone: _____

Insured SS#:_____ - _____ - _____

Name of Insured: _____ Insured DOB: _____

Employer: _____ Group#: _____

Pre-authorization required: Y N Pre-auth Phone: _____

Pre-authorization number: _____

**Secondary Insurance:** _____ Policy #: _____

Address: _____ Phone: _____

Name of Insured: _____ Insured DOB:_____

Insured SS#: _____ Employer: _____

Group#: _____

Pre-authorization required: Y N Pre-auth Phone: _____

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**AUTHORIZATION TO RELEASE INFORMATION TO ROCKY MOUNTAIN MEMORY CENTER**

PATIENT NAME: PLEASE LIST CURRENT DOCTORS

DATE OF BIRTH:

I hereby authorize the person, agency, or organization named herein to release any and all information pertaining to my care to Rocky Mountain Memory Center and their professional associates.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

The following information is requested at this time with regard to my care:

_____ **History and Physical Examination-to include medical diagnoses**

_____ **Discharge Summary**

_____ **Current Medications**

_____ **Neuroimaging results, including results of head CT and/or MRI**

_____ **Neurological Consultation**

_____ **Sleep Study**

➡ _____ ➡ _____

Signature of Patient/DMPOA/Legal Guardian Date

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# Notice of Privacy Practices

**Uses and Disclosure of Health Information**

Rocky Mountain Memory Center and its professional associates, uses and discloses your protected health information for treatment, payment, and healthcare operations. Specifically, information may be used for the following purposes:

- Sharing test results with other healthcare providers for confirmation of a diagnosis.
- Providing your diagnosis or other information about your healthcare to your insurance provider or our billing service to obtain payment for the healthcare services provided.
- Reviewing information as part of a quality improvement program.

**Uses and Disclosures Requiring Authorization**

Rocky Mountain Memory Center and its professional associates will make other uses and disclosure of protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying my office in writing that you wish to revoke your authorization.

**Uses and Disclosures for Other Reasons Without Authorization**

- Compliance with all laws, including report of suspected abuse, neglect, or violence. Specifically, if there appears reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited, or is at eminent risk of one of these factors.
- Responding to court or administrative orders, subpoenas, discovery requests, or other lawful process. Requests for information about your diagnosis and treatment while involved in a court proceeding is privileged under state law and will not be released without your written authorization or a court order.
- However, the privilege does not apply when you are being evaluated, or a third party, or where the evaluation is court-ordered.
- When necessary to avert a serious threat to health or safety.
- Disclosures for health oversight activities, including audit by Medicare or Medicaid or for investigation of possible violations of healthcare laws.
- Disclosures relating to Workers' Compensation programs.

**Patient Rights Regarding the Privacy of Your Health Information**

Subject to limitation outlined by law, you have certain rights related to the use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, Rocky Mountain Memory Center is not obligated to agree to requested restrictions;
- Receive confidential communications by alternate means and at alternate locations;
- Inspect and copy your protected health information with some limited exceptions;
- Amend your health information;
- Receive an accounting of disclosures of your health information;
- Obtain a paper copy of this notice.

**Practice Duties Regarding the Privacy of Your Health Information**

- Subject to limitations outlined by law, Rocky Mountain Memory Center and its professional associates, has certain duties related to your protected health information including: Rocky Mountain Memory Center and its professional associates is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Rocky Mountain Memory Center and its professional associates are required to abide by the terms of the privacy notice that is currently in effect.
- Rocky Mountain Memory Center and its professional associates reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in the office and available upon request.

**Acknowledgment of Notice of Privacy Practices**

Your signature acknowledges your receipt of a copy of this notice regarding the use and disclosure of your health information. The signed acknowledgment will be retained in your medical record.

_____ _____

Signature of Patient/DMPOA/Legal Guardian Date

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**Consent for Neuropsychological Evaluation and Limits of Confidentiality**

I understand that the purpose of this evaluation is to provide information about me for my physician or other health care provider who has requested the evaluation in order to assist in their diagnosis and treatment of me. The material from the interview and neuropsychological therapy testing will result in the generation of a report that will provide information related to diagnosis and treatment of me.

- The report generated by Rocky Mountain Memory Center and its professional associates will be sent to my physician or other health care provider and Dr. Lauren or her associates will also discuss the results of the evaluation with them.
- If desired by me or my referring provider, Dr. Lauren or her associates will also discuss the results with me and any others which I so designate by signing a release of information allowing Dr. Lauren or her associates to do so.
- If this evaluation is being covered or partially covered by my insurance Rocky Mountain Memory Center may be required to provide the insurance company with a report as well.
- I may request a copy of the report be sent to another person or agency at any time in the future by completing an additional Release of Information.
- This report, and any other information discussed in the evaluation is confidential, and it will not be shared without my permission except under the following conditions:
- Threat of suicide
- Threat to physically harm or endanger another person
- Known or suspected child abuse or abuse of an elderly person

The terms of this evaluation had been reviewed, understood and agreed to by me.

➡ _____ ➡ _____

Signature of Patient Date

➡ _____

(Please Print Patient Name)

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## Professional Services

At RMMC we specialize in neurocognitive disorders associated with aging, neurological disease, adult attention deficit, and mood spectrum disorders. We offer state of the art neurodiagnostic assessment as well education on brain function and the interrelationship between attention, memory and strategic problem solving. At RMMC, patient education is as important as the diagnosis itself.

Our evaluation model is based on a biopsychosocial perspective and begins with a neurobehavioral interview and record review carefully integrating recent health issues, life changes and environmental stressors with prior learning style, genetic history and family background. Individual testing allows us to assess various measures of attention, information processing, motor and sensory abilities, language and spatial skills, problem solving, memory and intellectual function. You may be asked to complete several neurobehavioral questionnaires dependent upon the reason for referral.

At RMMC we make every effort to ensure the evaluation process is a non- threatening and successful experience. In fact, many patients comment that while the testing was challenging, it was fun, stimulating and a "good way to get their brain working again". After medical records are received, evaluation materials are scored and processed; you will be called to attend a feedback session. You are encouraged to bring your family if you like. Dr. Lauren will review the test results and diagnosis, identify cognitive strengths and potential areas of weakness, answers your questions as well as offer common sense recommendations and follow up referrals as necessary.

Our Multimodal Cognitive Therapy program offers the latest research in education, instruction and intervention for adults with spectrum cognitive disorders seeking to improve the skills required to live and thrive independently. The program offers an integrative and pragmatic approach to improving cognition by combining education on memory and brain function, compensatory life skills training, learning strategies, brain wellness and computerized cognitive training. The program, including its educational materials, notebooks and learning tools were developed by Dr. Lauren specifically for her patients at Rocky Mountain Memory Center. Let us tailor a program to meet your individual cognitive needs.

## Insurance Coverage

Dr. Kathleen Lauren and Rocky Mountain Memory Center is a Medicare provider as well as a participating provider with a number of major insurance carries.

In accordance with CMS standards of practice, neuropsychological service will be billed by the hour and will include time to administer tests, score tests, interpret tests/interview/records, prepare the report, and provide necessary feedback to the patient/family. For non-forensic cases, this will typically add 7-8 hours to the actual testing time and will be billed together following conclusion of the evaluation.

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## What You Should Expect to See on Your Insurance Statement

In accordance with independent insurance standards, including the Center for Medicare (CMS): Neuropsychological and psychological service will be billed by the hour and will include time to administer tests, score tests, interpret tests/interview/records, prepare the report, and provide necessary feedback to the patient/family.

## Typical Billing Codes

Evaluation, Feedback and Treatment Codes

| Code | Service | Typical # Hours |
|---|---|---|
| Billed Date of Interview | | |
| 96132, 96133 | Neurobehavioral status exam | 2 hrs. |
| 96132, 96133 | Professional time: Psychologist's time both face-to-face time with the patient and time interpreting test results and preparing the report. | 2 hrs. |
| 96116, 96121 | Neurobehavioral, Executive Function, Personality and Attention Questionnaires | 2-4 hrs. |
| Billed Date of Testing | | |
| 96138 | Technician time to administer, score and prepare assessments, questionnaires, and patient materials | 5 hrs. |
| 96139 | Additional time needed by Technician | 3 hrs. |
| Billed Date Report Generated | | |
| 96132, 96133 | Professional time for preparing dictation. | 8 hrs. |
| 96132 | Therapist time for preparing plan, report | 1 hr. |
| Billed Date of Feedback | | |
| 96132 | Psychologist's time to review test results with patient and family | 1-2 hrs. |
| 96133 | Psychologist's time to provide further therapeutic interpretation of test results. | 45 min. |
| Billed Date of Treatment | | |
| 90837 | Computerized neuropsychological assessment | 1 session |
| 97129, 97130 | Psychologist's time to perform therapeutic evaluation | 30-45 min. |
| 90837 | Therapist's time to perform therapeutic treatment | 30-45 min |
| 90837 | Cognitive education materials: MyBrain; Guide To Brain Health ; MyBook, Brain Wellness Notebook | 1 session |

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**Charges, Service and Late Fees and Collection Policy** **PLEASE INITIAL AND SIGN**

This agreement is to inform you of your financial obligation to our practice. We are pleased you have chosen to come to our clinic. Please do not hesitate to request clarification of any clinic policies or ask any other questions regarding your service. This financial agreement is intended to facilitate our ability to provide excellent service to you as well as other patients while minimizing our administrative costs.

**Guarantee of Payment**

For value received, the undersigned guarantor (hereinafter "the Undersigned") and/or patient (hereinafter "the Patient") promises to pay to Rocky Mountain Memory Center (hereinafter "Provider") all charges incurred for services rendered to the Patient. Please read and initial.

1. The Undersigned authorizes the Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. The Undersigned authorize use of this form of all insurance claim submissions**.** _____

2. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) as a courtesy to the Undersigned in order to save you time and to facilitate payment to our office from your insurance company. The Undersigned understands by having our office process your insurance forms, that this does not eliminate your financial obligation for your treatment. It is ultimately the Undersigned responsibility to resolve any type of dispute over payments made or not made by the Undersigned insurance company. _____

3. The Undersigned understands that insurance is a contract between you and your insurance company. The Provider will not enter into a dispute with the Undersigned insurance company over any claim, although the Provider will submit necessary documentation the Undersigned insurance company requests to sort out any confusion or questions that may arise. However, it is ultimately the Undersigned responsibility to resolve any type of dispute over payments made or not made by the Undersigned insurance company**.** _____

4**. Credit Card on File**: By putting credit card information on file, I agree to allow practice to automatically charge the card for all appropriate services rendered including evaluation charges, deductibles, co-pays, secondary insurance, no shows and late cancellation fees. _____ CC# _____

**5. Service Charge Policy:** Returned checks will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually**). A service charge of 1.5% on the unpaid balance along with a late payment fee will be assessed after 3 months** : _____.

6. **Missed Appointment Fee**: Please notify us at least ***24 hours prior*** to your appointment if you need to cancel/reschedule. All appointments cancelled less than 24 hours prior to the appointment will be charged a missed appointment fee of $50. _____

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7. **PLEASE NOTE**: The reason for referral must meet stringent Medicare criteria for medical necessity. **RMMC does not provide evaluation for the following legal matters as they do not meet medical criteria**:

- Testamentary (Wills) • Guardianship • Conservatorship
- Contractual agreements (Revocation of DMPOA, Guardianship or Conservatorship)

We require you to initial and sign the payment agreement before we can begin to process your request of service. Your signature indicates you have read the above and agree to the terms contained therein. This agreement is irrevocable.

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

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PATIENT NAME: DOB:

**REASON FOR REFERRAL**

To better tailor an individualized neuropsychological examination to meet your needs, please describe your purpose for requesting a neuropsychological evaluation. Circle all that apply.

1. Differential diagnosis:
    - Psychiatric and or neurological disorder
    - Altered mental states associated with metabolic, systemic or toxic irregularity
    - Type and level of cognitive disorder
2. Acute changes in behavioral or cognitive functioning.
3. Early detection of age associated memory impairment or mild cognitive impairment.
4. Baseline evaluation to monitor changes associated with a degenerative type dementia or neurological disorders (Parkinson's, Multiple Sclerosis, brain tumors).
5. Assessment of neurocognitive functions for the formulation of rehabilitative, behavioral and cognitive management strategies.
6. Justification and documentation for disposition decisions and various levels of residential care.
7. Adult capacity evaluations to assess functional activities of daily living required for independent living. Ability to independently manage:
    - Medications • Bill paying and finances • Nutritional needs and meal preparation

**What are the <u>specific behaviors or issues</u> you would like addressed in recommendations:**

_____

_____

_____

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