Melbourne MedPsych
Clinical Psychology/Neuropsychology
Gerald Showalter, Psy.D., Licensed Psychologist/Clinical Neuropsychologist
1915 Oak Street, Melbourne, FL 32901
Ph: (321) 342-2768; Fax: (321) 450-1500

Client Information

Client Name:________________________________ Birthdate:_____________ Age: _________

Address:___________________________________

City: ___________________________________ State: __________ Zip Code: ___________

Home Phone:_________________________ Cell Phone:_____________________

Email Address: ____

Employer:____

Work Phone: _____________________________

Referred By:____

Name of Primary Care Physician:____

Person Responsible for Payment:____

Primary Insurance Information: ____

Secondary Insurance Information: ____

Copayment Due:________________________ Amount Paid:______________________

Melbourne MedPsych
Clinical Psychology/Neuropsychology *1915 Oak Street, Melbourne, FL 32901*
Gerald Showalter, Psy.D., Licensed Psychologist/Clinical Neuropsychologist *Ph: (321) 342-2768; Fax: (321) 450-1500*

CONSENT TO PARTICIPATE IN EVALUATION/TREATMENT SERVICES

I, _________________________, an applicant for services, authorize Dr. Showalter to provide psychological/neuropsychological evaluation, counseling/psychotherapy, and/or related consulting services.

Confidentiality
Your identity and any information shared by you will be kept confidential. The right to release information about you belongs to you. No information, including the fact that you are being seen by this office will be released to anyone without your written permission.

Exceptions to this policy are made as a result of legal requirements to report:

- the abuse or neglect of a child or a dependent adult.
- imminent danger of hurting yourself or someone else.
- in cases of court involvement, your treatment record may be obtained by a judicial order in compliance with applicable HIPAA regulations.
- information regarding your involvement in treatment (e.g., dates of treatment and billing record) may be released in the event that legal collection action becomes necessary by our office.
- information regarding your treatment, dates of service, diagnosis and treatment plans will be released to your insurance company if you choose to have our office file your insurance claims.

Patient Billing Information
Unless other payment arrangements are made and agreed upon in advance, your insurance claim will be processed through our office. You are responsible for payment of any portion of your bill which the insurance company does not cover. If you choose to have our office process your insurance, information regarding your treatment and diagnosis will be released to your insurance company. Dr. Showalter reserves the right to take any legal measure to collect delinquent accounts, including the use of collection agencies. If these actions become necessary to collect payment, your signature below documents that you agree you will be responsible for all attorney, court and collection fees involved in collection. Missed appointments without 24 hours notice will be charged to you at standard rates.

I HAVE READ, I UNDERSTAND, AND I AGREE TO ALL OF THE ABOVE.

____ ____________________
Client Signature Date
(Parent, if client is a minor child)

____ ____________________
Witness Date

INFORMED CONSENT FOR THE APPLICATION OF TEST PROCEDURES

Procedure: Psychological/Neuropsychological Test Battery.
I understand that I am being seen for a psychological/neuropsychological evaluation. The evaluation will include an interview, record review, and testing with various measures of attention, motivation, motor and sensory abilities, language and spatial skills, problem solving, memory, intellectual functioning, and emotional or personality functioning. I may request further information about any of these procedures, and I understand that I am free to withdraw from or decline to continue with testing at any time. I also agree to indemnify and hold Dr. Showalter and Melbourne MedPsych harmless from any viral or other infectious process (including, but not limited to COVID-19) to which I might be exposed in the course of participating in any and all interview, evaluation, consultation, feedback or treatment services within the Melbourne MedPsych offices. This evaluation is scheduled for a half day, with breaks available as needed. I may finish the evaluation on another day if needed to give my best performance. Feedback will be provided at a follow up visit that will be scheduled when the report summarizing test findings is completed.

1) Typical costs. A typical evaluation is comprehensive and includes not only the time spent directly with the patient, but also time spent reviewing records, scoring the tests administered, interpreting the results, and writing the report. Depending on the complexity of the evaluation, this can add 4 – 8 hours to the direct contact time. If I am covered by an insurance company that Dr. Showalter is contracted with (e.g., Medicare and many of the other major insurers), then he will accept that contracted rate plus my copay. Otherwise, the typical cost for a neuropsychological evaluation is $1500 to $2,000. Forensic fees are higher given the added complexity, risk and time requirements involved. Additional information on fees is available upon request.

2) Payment Issues

- **Payment due before session.** My portion of payment is due at time of service, paid before the session, unless arrangements are made in advance.
- **Assignment of benefits.** By signing below, I am authorizing the insurance company to pay benefits to Dr. Showalter. When Dr. Showalter bills the insurance company, payment for services is thereby directed to him; if the insurance company accidentally sends the check to me, it is my responsibility to turn the check over to Dr. Showalter. Dr. Showalter may need to communicate certain summary information to my insurance company in order to obtain authorization and payment for this evaluation.
- **Self-Pay.** For patients with insurance plans that Dr. Showalter is not contracted with, a self-pay arrangement is available. In a self-pay arrangement, Dr. Showalter will, if requested, assist me in billing my insurance company, but will leave that ultimately between me and my insurance company. I will be responsible for payment of the evaluation (via cash, check, cashier's check or money order) at the time of service.

3. I am welcome and encouraged (but not required) to bring my husband/wife/spouse or significant other to the interview and feedback sessions.

I understand and agree with the above.

____________________________________ _______________
Signature of Patient Date

____________________________________ _______________
Signature of Legal Guardian, if applicable Date

Melbourne MedPsych
Clinical Psychology/Neuropsychology *1915 Oak Street, Melbourne, FL 32901*
Gerald Showalter, Psy.D., Licensed Psychologist/Clinical Neuropsychologist *Ph: (321) 342-2768; Fax: (321) 450-1500*

AUTHORIZATION FOR RELEASE OF INFORMATION

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize ____and/or his or her administrative and clinical staff to release ____
____DOB:_____________________________________

This information should only be released to:
____
____

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

____

This authorization shall remain in effect unless you specify a different date below:

____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_______________________________ _________________
Signature of Patient Date
(or guardian or authorized representative if the client is incapacitated and/or a minor)

____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Melbourne MedPsych
Clinical Psychology/Neuropsychology
Gerald Showalter, Psy.D., Licensed Psychologist/Clinical Neuropsychologist
1915 Oak Street, Melbourne, FL 32901
Ph: (321) 342-2768; Fax: (321) 450-1500

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been made aware of this office's Notice of Privacy Practices, and that a copy of this Notice has been made available to me.

____________________________________ ______________________
Signature of Patient/Patient Representative Date

____
Relationship to Patient

AGREEMENT TO KEEP TEST MATERIALS/INFORMATION CONFIDENTIAL

As part of my participation in evaluation services through Melbourne MedPsych, I acknowledge I will be presented with test questions and materials that, although necessary for my evaluation, are not intended to be disclosed to the general public. This is so that test information and materials can be kept secure for other examinees. I agree, as part of my agreement to participate in evaluation services, to keep all test items and materials confidential. I agree not to record the interview or testing with the testing technician. I agree not to take pictures or other copies (whether by electronic or other means) of any test materials, or to take such materials from the offices of Melbourne MedPsych.

____________________________________ ______________________
Signature of Patient/Patient Representative Date

____
Relationship to Patient

Melbourne MedPsych
Clinical Psychology/Neuropsychology *1915 Oak Street, Melbourne, FL 32901*
Gerald Showalter, Psy.D., Licensed Psychologist/Clinical Neuropsychologist *Ph: (321) 342-2768; Fax: (321) 450-1500*

Payment Terms for Services Provided

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.

4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.

6. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.

7. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.

8. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

9. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

Melbourne MedPsych
Clinical Psychology/Neuropsychology
Gerald Showalter, Psy.D., Licensed Psychologist/Clinical Neuropsychologist
1915 Oak Street, Melbourne, FL 32901
Ph: (321) 342-2768; Fax: (321) 450-1500

Acknowledgement of Payment Terms

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

SIGNATURE ___________________________________ DATE___________________________

Melbourne MedPsych
Clinical Psychology/Neuropsychology *1915 Oak Street, Melbourne, FL 32901*
Gerald Showalter, Psy.D., Licensed Psychologist/Clinical Neuropsychologist *Ph: (321) 342-2768; Fax: (321) 450-1500*

Medical Information

Date:________

Client Name:_______________________________Birthdate:________________Age:_________

Present State of Health: ___Good ____Fair ____Poor

HAVE YOU EVER HAD: (please check at right of each item)

INFIRMITY	YES	INFIRMITY	YES
Severe and frequent headaches	____	Loss of leg, arm, finger, toe	____
Frequent dizzy spells	____	Bone, joint, or other deformity	____
Severe head injury	____	Blackout spells	____
Difficulty with vision	____	Seizures	____
Buzzing or ringing in ears	____	A stroke	____
Sinus trouble	____	Frequent crying spells	____
Allergy to pollen, weeds, dust	____	Trouble sleeping	____
Severe tooth or gum trouble	____	Earaches	____
Anemia or blood disease	____	Paralysis	____
A heart attack	____	Stomach ulcers	____
Palpitations or pounding heart	____	Frequent indigestion	____
Pain (estimate degree 1 to 10)	____	Appendicitis	____
High blood pressure	____	Liver disease	____
Rheumatic fever	____	Cancer	____
Asthma or wheezing	____	Frequent diarrhea	____
Emphysema	____	Frequent constipation	____
Pneumonia	____	Recent gain/loss of weight	____
Shortness of breath	____	Loss of appetite	____
Gonorrhea	____	Goiter or thyroid trouble	____
Syphilis	____	Diabetes	____
Any broken bones	____	Do you take insulin or pills for diabetes	____
Allergies	____	Any drug or narcotic habit	____

OTHER MEDICAL CONCERNS: