



Montana  
Neurobehavioral  
Specialists

Psychotherapy  
Neuropsychology  
Psychiatry  
Neurology

We'll take care of your head. You get on with your life.

Robert A. Velin, Ph.D.  
Bozeman Satellite Office  
1184 N. 15<sup>th</sup>, Suite 3  
Bozeman, MT 59715  
(406) 543-9700

Welcome to Montana Neurobehavioral Specialists. Thank you for allowing us to serve your healthcare needs. Our mission is to provide you with quality healthcare in a professional, efficient and caring manner. We have enclosed several documents that will help you in preparing for your upcoming appointment. Please fill out and bring ALL enclosed documents with you to your appointment.

***Insurance Coverage Worksheet:***

If you have insurance, it is your responsibility to verify any need for referral, pre-authorization or co-pay. We have enclosed an Insurance Coverage Worksheet to assist you when you contact your insurer. Failure to contact your insurance company may result in payment denial of your claim (and you being solely responsible for the charges).

***Financial Policy:***

This document details your financial responsibility as it relates to the care you will receive. Any questions concerning this policy can be directed to our Patient Accounts Coordinator at (406) 543-2900.

**Appointment Information:**

Appointment times are reserved for your specific needs. If you cannot keep your appointment, please notify our office at least 24 hours in advance.

**Care For Minors:**

The parent or guardian authorizing care for a minor will be the financially responsible party for that patient's account.

**Map to Montana Neurobehavioral Specialists:**

For your convenience, a map is included with directions to our office as well as the office phone number.

Thank you for choosing Montana Neurobehavioral Specialists.

Sincerely,

*The Doctors and Staff of Montana Neurobehavioral Specialists*

Appointment Dates and Times:

Initial Interview: \_\_\_\_\_

Testing: \_\_\_\_\_

Follow-up/Evaluation Results: \_\_\_\_\_



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## RESPONSIBLE PARTY FOR PATIENT (GUARANTOR)

Last Name:		First Name:	
Street Address:	City:	State:	Zip:
Home Phone:		Cell Phone:	
Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>			

## EMPLOYER INFORMATION

If patient is a child please fill in with parent's information	Mom	Dad
Employer:		
Address:		Work Phone:

## ALTERNATE MAILING ADDRESS (if different from Guarantor)

Street Address:	City:	State:	Zip:
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## PATIENT INFORMATION

First Name:	Middle Initial:	Last Name:
Date of Birth (patient):	Date of Birth (insured):	M <input type="checkbox"/> F <input type="checkbox"/>
Name of Physician/Person Referring you to us:		
Name of Primary Care Physician:		
Social Security Number:		
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Other <input type="checkbox"/>		
Have you seen any other doctors within MNS? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If so, which doctor?		
How did you hear about our practice?		
Phone Book <input type="checkbox"/> Friend <input type="checkbox"/> Other Advertisement <input type="checkbox"/> Referred by Physician <input type="checkbox"/>		
Other: _____		

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## INSURANCE INFORMATION

**If you have your insurance card with you we will need to make a photocopy for our records. If you have a co-pay please make check payable to the physician you are seeing.**

Policy Holder's Name:		Policy Holder's Date of Birth:		
Primary Insurance:				
Relationship to Patient:    Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>				
Policy #		Group #		
Policy Holder's Name:		Policy Holder's Date of Birth:		
Secondary Insurance:				
Relationship to Patient:    Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>				
Policy #		Group #		
<b>EMERGENCY CONTACT INFORMATION</b>				
Last Name:		First Name:	Phone:	
Mailing Address:	City:		State:	Zip:
Relationship to Patient (relative, friend, neighbor, etc.)				

It is the patient's responsibility to obtain any necessary referrals or pre-authorizations from their insurer or primary care doctor. Failure to verify the need for a referral with your insurer may result in a denial of payment by the insurance company.

Patients without insurance coverage are required to pay for services at the time of their visit. All patients are required to pay co-pays or other cost shares at the time of service. Requests for special reports may require payment in advance.

Fees will vary based on the doctor's specialty and the length and complexity of the visit.

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Signature

Date

<p style="text-align: center;"><b>MONTANA NEUROBEHAVIORAL SPECIALIST</b> <b>FINANCIAL POLICY</b></p>
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**Insurance Coverage:** Many insurance companies require pre-authorization and/or referral prior to obtaining specialty care. It is your responsibility to contact your insurer to determine the need for a referral and/or pre-authorization. Failure to obtain the referral and/or preauthorization may result in lower payment or claim denial from the insurance company. Please bring your insurance card with you to your appointment as well as your co-pay.

**Private Insurance Patients:**

- Contact your insurer prior to your visit to verify coverage and determine your co-pay responsibility
- Please bring your insurance card
- Co-pay is expected at the time of your visit

**Self-Pay Patients:**

- For visits under \$200, payment in full is expected at time of service
- For visits over \$200, payment of 50% of the fee is expected unless payment plan arrangements have been made with our business office

**Medicaid Patients:**

- Contact your passport provider for authorization prior to your appointment
- Please bring your current Medicaid card
- Co-pay, if applicable, is expected at the time of your visit

**Motor Vehicle Accident Patients:**

- MVA patients are ultimately self-pay patients. You will receive a bill directly from our office that you can submit to your carrier/attorney.

Ultimately, any account balance is your responsibility, regardless of anticipated insurance payment. We will gladly process any private insurance claims at the time of service. Any balance remaining after payment is received from your insurer will be billed to the responsible party, and is payable within three (3) months.

**Payment Options:** You may pay your out-of-pocket costs at the time of service by check, cash, or credit card. If you are unable to pay your full out-of-pocket costs at the time of service you may make payment arrangements through our Business Office. These options include: a payment plan not to exceed one month on amounts less than \$250.00 and three months on amounts over \$250.00

**Past Due Accounts:** If at any time you have a balance due which is more than 30 days old and have not made appropriate payment arrangements with our Business Office your account may be referred to an outside collection agency.

If you have established a payment plan and default on the agreed upon plan your account may be referred to an outside collection agency. If we have to refer your account to a collection agency, you agree to pay for all of the collection costs that are incurred. Further, you understand that if your account is submitted to a collection agency, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

**Returned Check Fee:** There is a fee of \$25 for any checks returned by your bank.

**Divorce:** The parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Effective Date:** Once you have signed the agreement for our financial policy (attached to the demographic section in this packet), you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.



## Assignment and Release:

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Patient Name (Last, First, MI)

Date of Birth

I acknowledge that Montana Neurobehavioral Specialists may release to third party payers requested medical and/or other information necessary to process my claim(s). I recognize that this information may include medical, psychological and psychiatric information and diagnosis. I hereby assign to Montana Neurobehavioral Specialists all benefits which are or shall become payable from any third party payer who is responsible for payment of my Montana Neurobehavioral Specialists expenses. I authorize and direct all third party payers to pay all benefits directly to Montanan Neurobehavioral Specialists.

Patient and/or persons legally and financially responsible for patient's medical bills agree to pay patients account regardless of the existence of insurance or other third party liability. Full payment will be made promptly unless other credit arrangements are made. Montana Neurobehavioral Specialists is free to declare the entire balance to be due and payable if any scheduled payments are missed. The undersigned agrees to pay all costs of collection, including reasonable attorney's fees, if the account is not paid timely.

I authorize treatment of the person named above and agree to pay all fees and charges for any services.

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Patient Signature

Date

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Authorized Representative Signature

Date

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Relationship to Patient

**HIPAA PRIVACY NOTICE**

**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.**

The doctors and staff at Montana Neurobehavioral Specialists understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information", PHI for short. (PHI includes information that can be identified as yours). We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose your PHI and must comply with these policies. With some exceptions, we may not use or disclose any more of you PHI than is necessary to accomplish the purpose of the disclosure.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. If we make an important change to our policies, we will change this notice and post a new notice in our waiting areas. You can also request a copy of this notice from our office at any time.

**PERMITTED USES AND DISCLOSURES**

We can use or disclose your PHI for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular uses or disclosure in every category will be listed.

***Treatment:*** We may disclose your PHI to physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

***Payment:*** We may use and disclose your PHI in order to bill and collect payment for treatment and services provided to you. For example, your insurance may require clarification of the treatment given in order to determine the level of benefits available for that visit.

***Health care operations:*** We may disclose your PHI in order to operate this practice. For example, activities related to quality assurance, case management, receiving and responding to patient comments, physician reviews, and business planning may require the use of PHI.

**OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)**

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your PHI in the following ways:

- We may contact you to provide appointment reminders.
- We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may disclose to your family and friends or any other individual PHI directly relevant to such person's involvement with your care or payment for your care, unless you object.
- We will allow your family and friends to act on your behalf to pick-up prescriptions, x-rays, and other similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- Subject to applicable law, we may make incidental uses and disclosures of PHI. Incident uses and disclosures are by-products of otherwise permitted uses or disclosures of PHI. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

**YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION (PHI)**

***Request Limits on the Uses and Disclosures of Your PHI:*** You have the right to ask that we limit how we use and disclose your PHI. Requests to limit the use and disclosure to your PHI must be submitted in writing to the Practice's Privacy Officer. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

***Choose How We Send PHI to You:*** You have the right to ask that we send information to you to an alternative address or by alternative means. We must agree to your request so long as we can easily provide it in the format you requested. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. There may be charges for copies made.

***Right to See and Get Copies of your PHI:*** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing, to the Practice's Privacy Officer. In certain situations, we may deny the request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. There may be charges for copies made.

***Right to Get a List of Disclosures We Have Made:*** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that are made for treatment, payment, or health care operations. The list will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or pursuant to your authorizations. To request a list of disclosures of your PHI, you must submit your request in writing to the Practice's Privacy Officer. Your request must state a specific time period for the accounting (e.g., the past three months).

***Right to Correct or Update your PHI:*** If you believe there is a mistake in your PHI or that a piece of information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing to the Practice's Privacy Officer. We will respond within 60 days of receiving our request. We may deny the request if the PHI is:

- Correct and complete
- Not created by us
- Not allowed to be disclosed
- Not a part of our record

Our written denial will state the reasons for the denial and explain our right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

#### COMPLAINTS ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights have been violated, you should immediately contact the Practice's Privacy Officer. We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

#### CONTACT PERSON(S)

If you have any questions or would like further information about this notice, please contact the Practice's Privacy Officer:

Martina Rolando  
900 N. Orange St, 3<sup>rd</sup> Floor  
Missoula, MT 59802  
(406)327-3350

**MONTANA NEUROBEHAVIORAL SPECIALISTS**  
**1184 North 15<sup>th</sup>, Suite 3**  
**Bozeman, MT 59715**  
**(406) 543-9700**

**INSURANCE COVERAGE WORKSHEET**

Patient Name:	Appointment Date & Time Consult:
	Test Date:
Reason for Appointment:	
Doctor Being Seen:	Estimated Fee for Visit: 90801, 96119 & 96116 \$1600.00

The doctors and staff at Montana Neurobehavioral Specialists realize that health insurance and planning for medical expenses can be very confusing. Therefore, we developed this worksheet to assist you when you contact your insurer to verify coverage as it relates to your upcoming visit. Please take the time to obtain the answers to these questions and ***bring this form with you to your appointment.*** This information will allow our office to accurately submit your claims and will also provide you the necessary information to plan for any expenses for which you will be responsible.

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Name and Phone number of insurance representative: \_\_\_\_\_

Is a Referral or Pre-Authorization required for this visit?      Yes                  No

If Yes:

Date and Doctor referral requested from: \_\_\_\_\_

or

Pre-Authorization Number: \_\_\_\_\_

Does patient have a deductible?                  Yes                  No

If Yes, how much of the deductible is un-met at this time? \_\_\_\_\_

Does the patient have a co-pay for office visits?      Yes                  No

If Yes, what amount? \_\_\_\_\_

Estimated percentage the insurer will pay for this visit? \_\_\_\_\_

Method of payment to be used for any amount not covered by insurance:

Payment at time of service                  Pay off over three months

Request contact from the Business Office

# MONTANA NEUROBEHAVIORAL SPECIALISTS

## NEUROPSYCHOLOGICAL EVALUATIONS

The average charge for a full neuropsychological evaluation is approximately \$1600.00. This fee covers the initial diagnostic interview with the doctor, testing, review of test results and medical records, result interpretation by the doctor, meeting with the doctor to review the results and recommendations, and final report preparation.

Insurance coverage for these evaluations varies from insurer to insurer, therefore, the amount of your responsibility will also vary.

It is our office policy to collect **\$250.00** (15% of the average charge) from all patients scheduled for neuropsychological evaluations prior to formal testing. The balance due on the evaluation, after your insurance pays their portion, must be paid in full within three months of the date of the evaluation.

We accept personal check, Visa, MasterCard, Cashier's Check, or Money Order for payment purposes. *(We cannot accept cash payments.)*

*Please note: Patients covered by Medicare and Medicaid are excluded from this policy.*