



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

Welcome to Montana Neurobehavioral Specialists and Northwest Center for Cognitive Behavior Therapy. Thank you for allowing our doctors and staff to serve your healthcare needs.

Our mission is to provide you with quality healthcare in a professional, efficient and caring manner.

Appointment Information:

Enclosed you will find several documents and forms to help you prepare for your upcoming appointment. The documents explain our appointment and payment policies and your rights under the Health Information Privacy Act. The forms ask for information regarding your insurance coverage and current medications. Please bring the completed forms with you to your visit.

If at any time you have questions about our financial policy, or your account, please call our Business Office at 327-3370. The office is open daily from 8:00a.m until 5:00p.m.

We ask that you inform us 24-hours in advance if you are unable to keep your scheduled appointment.

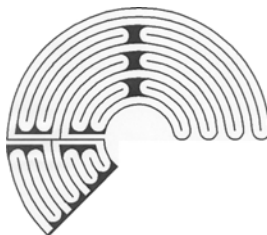
Map to Montana Neurobehavioral Specialists:

This map provides directions to our office as well as phone numbers for each of the doctors.

Thank you for choosing Montana Neurobehavioral Specialists and Northwest Center for Cognitive Behavior Therapy. We look forward to working with you.

Sincerely,

The Doctors and Staff of Montana Neurobehavioral Specialists and Northwest Center for Cognitive Behavior Therapy





Montana
Neurobehavioral
Specialists

Psychotherapy
Neuropsychology
Psychiatry
Neurology

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

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:
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Primary Insurance:

Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>
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Policy #	Group #
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Policy Holder's Name:	Policy Holder's Date of Birth:
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Secondary Insurance:

Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>
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Policy #	Group #
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EMERGENCY CONTACT INFORMATION

Last Name:	First Name:	Phone:
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Mailing Address:	City:	State:	Zip:
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Relationship to Patient (relative, friend, neighbor, etc.)
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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.

Signature

Date

<p style="text-align: center;">MONTANA NEUROBEHAVIORAL SPECIALIST FINANCIAL POLICY</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.

Work Comp patients: Please bring the name, address and phone number of your work comp carrier as well as the claim number assigned to your case.

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

Payment Options: You may pay your out-of-pocket costs at the time of service by:

Check Cash 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

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

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.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours notice, a missed appointment fee may be charged. This fee must be paid before a new appointment is scheduled. Patients with two or more missed appointments may be asked to transfer their records to another doctor.

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:

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.

Patient Signature

Date:

Authorized Representative Signature

Date:

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, 3rd Floor
Missoula, MT 59802
(406)327-3384 or (406)327-3350