Nusha LLC
PO BOX 1783
Cupertino, CA 95015
Phone: (669) 210-3757

PATIENT INITIAL APPOINTMENT INFORMATION & CONSENT FORM

Patient Name:_____Date: _____

Patient's Date of Birth:_____Social Security Number: _____

Patient's Address:_____

Home Phone:_____Alternate Phone: _____

Is it okay for us to leave messages for you at these numbers regarding your appointments? Yes/ No

Alternate Contact: _____

Relationship to Patient: _____

Address: _____

Home Phone:_____Alternate Phone: _____

Is it okay for us to leave messages for you at these numbers regarding your appointments? Yes/ No
Emergency Contact (check if same as above)

Name:_____Phone: _____

Who referred you to our office? _____

Who is your primary care doctor? _____

I acknowledge the above information is correct to the best of my knowledge.

_____ _____
signature date

STATEMENT OF INFORMED CONSENT

Nature and Purpose of Counseling and Assessment: Depending on your needs, we may need to do a memory screening, informational interview regarding your medical history and current concerns, informal assessments or formal neuropsychological assessment. The goal of neuropsychological assessment and memory consulting services is to determine if any changes have occurred in your attention, memory, language, problem solving or other areas of cognitive functioning. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your background and current medical symptoms, we may be using different techniques and standardized tests including, but not limited to, asking questions about your knowledge of certain topics, reading, drawing figures and shapes, working on a computer, viewing printed material and manipulating objects. For some individuals, assessment can cause fatigue, frustration and anxiety.

Limits of Confidentiality: The health Insurance Portability and Accountability Act of 1996 (HIPAA) established a privacy rule to ensure that health care providers obtain adequate consent from their patients for the use and disclosure of health information to carry out treatment, payment or health operations.

At Nusha LLC, we do all we can to secure and protect your privacy, providing only the minimum necessary information to those in need of your information regarding treatment, payment or health care operations. Information obtained during assessment is confidential and can ordinarily only be released with your written permission. There are some special circumstances that can *limit confidentiality*, including: a) a statement to harm self or others, b) statements indicating harm or abuse to children or vulnerable adults, and c) issuance of a subpoena from a court of law; or federal investigative bureau.

You may refuse to consent to the use or disclosure of your personal health information, but you must do so in writing. Under HIPAA, we have the right to refuse to treat you, should you refuse to disclose your personal health information as outlined above. If you choose to give consent in this document, at some future time you may request to refuse disclosure of all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or any previously signed consent.

I hereby consent to the use or disclosure of my protected health information as specified above.

Print name: _____

Signature_____Date _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Dr. Nusha Askari & Nusha LLC to release the following protected health information (PHI) from my clinical record:

O Neuropsychological Report
O Memory evaluation report
O Other: (Please Specify) _____

I authorize information regarding my care to be released to the following individuals:

O Primary Care Provider
O Referring Provider (If different):
_____
O Spouse
O Other Family Members: (Please Specify) _____
O Other Professions: (Please Specify) _____
O I request that a copy of the report be sent to me (the patient).

I would like to put the following limitations on this release: (Specify below)

_____

_____

This authorization shall remain effective until:

O The termination of treatment
O Expiration date determined by patient (Please Specify) _____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation to Nusha LLC at PO Box 1783 Cupertino, CA 95015. Notice of revocation will not be effective until received by Nusha LLC. I also understand that the purpose of this release is to assist with the facilitating communication between profession service providers, agencies or other individuals named in this document. I understand the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these risks. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

Signature_____Date _____

Signature of Patient Representative (if applicable) _____

If a patient representative signs this authorization form, a description of such representative's authority to act for the patient must be provided.

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STATEMENT OF FINANCIAL RESPONSIBILITY

Please read and sign this form that outlines financial responsibility for treatment:

1. The patient/client/guardian is financially responsible for services received. We only accept private pay, sorry, we do not accept insurance.

2. Payment is expected at time of service unless specific arrangements are agreed upon in advance. Finance charges of 5% will be charged each month for unpaid balances over 30 days. If a balance remains unpaid for an additional 30 days, your account may be referred to a collection agency. Any fees for additional collections will be added to your balance.

3. Cancellation policy: Failure to cancel an appointment within less than 48 hours of the appointment day and time will result in a $50 automatic charge or potentially the full cost of your appointment if we cannot fill that time. Multiple, repeated cancellations may result in discontinuation of service. Please note that failure to make timely payments may also result in referral to a Collection Agency, and subsequent legal and financial retribution.

4. If you request copies of information sent to another source or if you have given another source permission to review evaluations or other reports, there may be a charge for copying and mailing. If letters are written on your behalf, or extended or frequent telephone calls or e-mails made, additional hourly rates for services may apply for time over 10 minutes.

5. For your convenience, we accept cash, checks and credit cards. Please make your check payable to Nusha LLC. A $35 charge will apply on all returned checks.

Patient Signature:_____ Date: _____

Responsible Party Signature:_____ Date: _____

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