Mark McDonough, Ph.D.
Pediatric and Adult Neuropsychology
*4405 Manchester Ave, Suite 206, Encinitas, CA 92024
Phone (760) 944-9647 - Fax (760) 944-7491

FIRST APPOINTMENT CLIENT INFORMATION
(Please Print)

Today's Date: _____ **Is Patient a Minor?: Yes / No**

Patient: _____ **Sex: M / F**

If Patient is a Minor, Name of Financially Responsible Party (Parent(s)/Guardian(s)):

_____

Patient Date of Birth: _____ **Age:** _____

Patient address: _____

City/State/Zip: _____

( ) _____ ( ) _____
Home **Cell**

( ) _____
Work

Email for Patient or Parent/Guardian: _____

Referring Physician: _____ **or Not Applicable**

Phone:_____

Address _____

City/State/Zip _____

Referring Attorney: _____ **or Not Applicable**

Phone:_____

Address _____

City/State/Zip _____

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INSURANCE INFORMATION
(Please Print)

Subscriber Name (For Tricare Patients: Please list the SPONSOR information) :

_____

Relation to patient: SELF FATHER MOTHER HUSBAND WIFE OTHER:_____

Subscriber/Sponsor SSN:_____ Subscriber/Sponsor DOB:_____

Primary Insurance: _____Ins Phone: _____

Ins ID #: _____ Grp #: _____ PPO / HMO

Secondary Insurance: _____Ins Phone: _____

Ins ID #: _____ Grp #: _____ PPO / HMO

I understand the fee for service is $_____ and is due at today's appointment unless otherwise noted:

_____.

In signing below, I agree to be treated by Mark McDonough, PhD. I understand that I am financially responsible to Mark McDonough, PhD for all unpaid balances. I understand that, as my provider, Dr. McDonough is authorized to provide an unbiased assessment and that if I am in disagreement with his evaluation, I am still financially obligated to pay for services rendered. If the patient is a minor, the parent or guardian is the guarantor and is responsible for the charges. I authorize release of medical information necessary to process claims to our third party billing service for services rendered by Mark McDonough, PhD and San Diego Neuropsychology. San Diego Neuropsychology is not responsible for any misinformation received during the benefit eligibility look-up from patients' insurance benefit representatives. Office copays are verified as a courtesy; however, you may want to contact your insurance to find out if any additional costs apply. Fees not covered by insurance will be the responsibility of the patient to pay San Diego Neuropsychology P.C..

Each service is billed separately to insurance companies: clinical interview, each testing date, and meeting with Dr. McDonough to review test results and recommendations. Billing can take up to 60 days to process by insurance carriers from the last date of service. We make every effort to make sure patients who pay at the time of service and should be reimbursed by their insurance carriers are paid in a timely manner. Unfortunately, it is common for insurance carriers to mistakenly send payments to our office instead of to our patients. If this is the case, we will alert our patients as soon possible and issue them a check from our office. San Diego Neuropsychology Fees due from the patient not received within 30 days of billing will be increased by 10% to pay for additional billing services required to collect those fees.

Medicare Disclaimer: It is the responsibility of the patient to call his/her secondary/supplemental insurance for coverage information. San Diego Neuropsychology will check for Medicare Eligibility as a courtesy.

Medicare/Medi-Cal Participants: San Diego Neuropsychology PC (SDN PC) is NOT a Medi-Cal Provider. It will be the responsibility of the patient to notify SDN PC if they are enrolled in a Medi-Cal secondary/supplemental plan. As Medicare traditionally pays 80% of the cost of service for the evaluation, SDN PC respectfully requests the remining 20% (estimated to be around $318.47, however that amount is subject to change pending receipt of the EOB) at the time of service.

Cancellation Policy: We respectfully request at least 48 hours notice prior to your appointment if you need to cancel. Cancellation Fees (less than 48 hours): Clinical interview - $100.00 / Testing - $250.00

Signed (Patient): _____ Date: _____

Signed (Parent/Guardian): _____ Date: _____

San Diego Neuropsychology
Cancellation Policy

Cancellation Policy: We respectfully request 48 hour notice prior to your appointment if you need to cancel. Our cancelation fee details are listed below.

First Appointment - Clinical interview - $100.00

Second Appointment: Testing - $250.00 (The testing day is usually 6 or more hours. If we receive notice less than 48 hours in advance, we are not able to schedule another patient in that time slot and our doctors have lost a day of testing).

Last Appointment – Review of Testing - $100.00

We appreciate your adherence to this policy.

Signature: _____

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Mark McDonough, Ph.D.'s Notice of Information Practices. I understand that Mark McDonough, Ph.D. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Mark McDonough, Ph.D. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mark McDonough, Ph.D.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Counseling is considered confidential. In cases where there is a Social Worker, Probation Officer, Court Mandated counseling involved, this confidentiality may be limited. Where appropriate a Release of Information will be requested to be signed. In cases of Child Abuse (physical or sexual), Elder or Disabled Adult Abuse, Threats of Harm, there is a legal mandate to report such incidents to a protective agency or law enforcement.

I understand that during assessment testing, it may be necessary at times to audio tape record sections of tests to increase scoring accuracy. These tapes are used solely for the purpose of scoring assessments and are destroyed upon completion of that purpose.

This HIPAA statement is an abbreviated form of the 4 page statement by the Secretary of the U. S. Department of Health and Human Services. I understand that I am able to ask Dr. McDonough to read or to receive a copy of the full version of the HIPAA statement. My signature indicates that I have read the abbreviated HIPAA form/and or the extended form and Dr. McDonough's Notice of Information Practices.

_____

Patient Name

_____

Signature

_____

Date

San Diego Neuropsychology

Mark McDonough, Ph.D.

Pediatric and Adult Neuropsychology

4405 Manchester Ave., Suite 206, Encinitas, CA 92024

Phone: (760) 944-9647 • sandiegoneuropsychology.com • Fax: (760) 944-7491

Laraine Lipori, Psy.D. ***Laura Hopper, Ph.D.***

Consent and Authorization to Use or Disclose Information

I, _____ (Patient), hereby authorize Mark McDonough, Ph.D. to receive/disclose information/ records obtained in the course of my assessment and/or treatment to/from:

Name: Laraine Lipori, Psy D (Psychologist), Laura Hopper, Ph.D. (Psychometrist), E-Billing Solutions, Dalene Marquez (Forensic Coordinator), Desiree Arrasmith (Billing Specialist), Tim Peterson (Office Assistant), Chelsea Chang (Office Manager).

Name: _____ ☐ Send report

Address: _____

_____

Name: _____ ☐ Send report

Address: _____

_____

Name: _____ ☐ Send report

Address: _____

_____

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of this authorization must be provided by me in writing and received by Dr. McDonough at 4405 Manchester Ave, Suite 206, Encinitas, CA 92024

The purpose of information and records disclosure authorized by the Patient:

_____

The specific uses and limitations of the information to be disclosed:

_____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable [state] law may protect such information.

This authorization shall remain valid for:
☐ 1-year from today or ☐ Terminate on date: _____

Signature of Patient or Parent/Guardian: _____ Date: _____