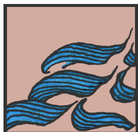


Rio Grande Neuroscience | Dr. Jill Ryan and Associates

Jill Ryan, Ph.D.
Clinical Neuropsychology

CLIENT INFORMATION SHEET

DATE: _______________

PLEASE PROVIDE ALL THAT APPLY:

Client Name: ________________________ DOB: ____________ SS#: _____-____-_____

Client Address: ____

City: ______________________________ State: _________________ Zip: _____________

Phone: _________________ E-mail: ______________________

Appointment Contact: _____________________ Phone: _________________

Relationship to Client: ___________________ Primary Doctor: __________________________

Referral Information:

Referring Doctor: _______________________ Phone Number: _______________

Reason for Referral: ____

____

Insurance – COMPLETE this section if insurance is to be considered as a payment source:

Medicare Number: ______________________ Effective Date: _______________

Medicare Provider: ____

Medicaid Number: ______________________ Effective Date: _______________

Medicaid Provider: ____

Commercial/Other Insurance: ____

Member Name: __________________________ Policy Holder Name: _______________________

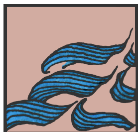
Member #: _____________________________ Group #: __________________________________

If patient is a minor under 18, or an adult with a legal guardian, parent or guardian MUST sign consent to treat prior to scheduling and appointment.

Patient is (check one): Under 18 Adult with Guardian N/A

Name of Parent/Guardian: ______________________________ Date: ___________________

Agency: ___________________________ Phone and E-mail: _____________________________



Rio Grande Neuroscience | Dr. Jill Ryan and Associates

Jill Ryan, Ph.D.
Clinical Neuropsychology

CONSENT TO TREAT

Client's Name: ______________________________ DOB: ________________

Thank you for contacting my office for professional mental health services. I am licensed as a clinical psychologist in New Mexico and offer the following services as my schedule allows:

- Geriatric and general adult (age 16 and older) neuropsychological and psychological assessment
- Individual and group health psychology (on a limited as-is-available basis)
- Working Memory Training

1. I am contracted with Medicaid, Medicare and some private insurance companies. If the service is medically necessary and covered by contract with an insurance company, then I accept the contracted rate. The client accepts responsibility for their contracted copay and deductible, and for any service that is not covered.
2. If the requested service is not covered by insurance (i.e., educational testing, cognitive retraining, guardianship or disability evaluations) you will be notified of my standard fee. I will not be bound by your insurance provider's contract rate if the requested service is not covered by insurance.
3. If you do not have insurance, you will be notified of my standard fee.
4. Upon request, a sliding scale rate might be available for those who fall within the federal poverty guideline.
5. Information disclosed by clients is considered privileged and confidential. By signing below, you acknowledge that you received copy of my HIPAA policy. Under HIPAA, in many cases I will get your consent before I share your information. However, the law provides that in certain situations, I am not required to get your consent to share your information, including the following:
   a. I may share your information with your doctor so you can get medical care or with your health insurance provider or representative in connection with your insurance coverage.
   b. If I have reason to believe a client is the victim of exploitation, abuse or neglect.
   c. If I have reason to believe a minor child is the victim of exploitation, abuse or neglect.
   d. If I am told or if I have sufficient reason to believe that a client intends to harm or injure another person.
   e. If I am told or if I have sufficient reason to believe that a client seeks to harm or injure himself/herself.
   f. If mental health services are court-ordered or if I receive a subpoena or other legal process.
   g. If a governmental agency demands your information, or if your information is demanded for lawful national security purposes.
6. By signing below, you agree to assume financial responsibility for any service or amount not compensated by a third-party payer. Your balance must be paid in full before a written report will be released. Balances unpaid after 30 days are subject to an 18% service fee.
7. By signing below, you acknowledge that you received my Office Policies and Procedures, and agree to abide by them.

SIGNATURE AND ACKNOWLEDGEMENT OF CONSENT TO TREAT

I have read the above information and agree to receive mental health services from Dr. Ryan or her staff under these terms. **If a guardian or parent, I agree to permit Dr. Ryan or her staff to provide psychological treatment to my child or an adult for whom I am the legal guardian.**

Signature: ________________________ Date: ____________________

Printed Name: ______________________ Relationship to Client: ________________

600 Central Avenue SE, Suite 221, Albuquerque, NM 87102 | (505)345-9288 | Fax (505)212-0359
info@riograndeclinic.com | www.riograndeclinic.com