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: _____

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

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* * * CONSENT TO TREAT * * *

Client's Name: _____ DOB: _____

Thank you for contacting Rio Grande Neuroscience (RGNS) for professional mental health services. As required by law, RGNS providers are licensed in New Mexico. We offer the following services (as scheduling allows):

- Geriatric and general adult neuropsychological and psychological assessment
- Individual psychotherapy
- Working Memory Training

Services are covered in one of the following ways:

☐ RGNS is contracted with Medicaid, Medicare and some private insurance companies. If the service is medically necessary and covered by contract with your insurance company, then we accept the contracted rate. You accept responsibility for the contracted copay and deductible amounts, and for any service that is not covered by insurance.

☐ If the requested service is not covered by insurance (i.e., educational testing, cognitive retraining, guardianship, disability evaluations) you will be notified of the standard fee. If the fee is paid privately, you agree not to submit the invoice to your insurance company.

☐ If we are not contracted with your insurance company for the services being rendered, you will be notified of RGNS standard fee. RGNS will not be bound by your insurance provider's contract rate if the requested service is not covered by insurance. If the fee is paid privately, you agree not to submit the invoice to your insurance company.

☐ If you do not have insurance, you will be notified of RGNS standard fee.

Information disclosed by clients is considered privileged and confidential. By signing below, you acknowledge that you were offered a copy of my HIPAA policy. As needed, RGNS will get your consent to share information with others involved in your care. The law provides that in certain situations, we are not required to obtain your consent to share information:

a. If requested by your health insurance provider or representative in connection with your insurance coverage.
b. If we have reason to believe a client is the victim of exploitation, abuse or neglect.
c. If we have reason to believe a minor child is the victim of exploitation, abuse or neglect.
d. If we are told or have sufficient reason to believe that a client intends to harm or injure another person.
e. If we are told or 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 we 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.

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.

SIGNATURE AND ACKNOWLEDGEMENT OF CONSENT TO TREAT

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

Signature: _____ Date: _____

Printed Name: _____ Relationship to Client: _____

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CONSENT TO RELEASE INFORMATION

Client's Name: _____ DOB: _____

I authorize Rio Grande Neuroscience (RGNS) to discuss and mutually exchange information, records and/or reports regarding client's treatment, symptoms, diagnoses, behaviors, prognosis and any other clinical or case-management issues with client's physician, other clinicians involved in client's care and any entity providing services including, but not limited to the New Mexico DD Waiver, the New Mexico Mi Via Waiver or New Mexico State General Fund.

And (if applicable):

- ☐ Spouse/life partner
- ☐ All siblings
- ☐ All adult children
- ☐ All family members
- ☐ All family members and all others visiting at nursing facility
- ☐ Others: _____

_____

I authorize reports, should any be generated, to be sent to:

Name: _____ Name: _____

Fax Number: _____ Fax Number: _____

Address: _____ Address: _____

_____ _____

I may revoke this authorization at any time by so informing RGNS in writing.

I have read the above information and agree to the terms cited. If a guardian or parent, I agree to the terms cited regarding treatment of my child or an adult for whom I am the legal guardian.

_____ _____

Signature Date

Printed Name: _____ Relationship to Client: _____

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OFFICE POLICIES AND PROCEDURES

- Dr. Ryan adheres to all Health Insurance Portability and Accountability Act (HIPAA) regulations.
- The waiting room is a shared space. Please be respectful of others and their needs.
- Patients are requested to refrain from wearing perfumes or scents out of concern for others with environmental sensitivities.
- There is a therapy dog in training at the office. If you are allergic to dogs or would prefer not to have the dog present when you come for your appointment, please let us know. We accommodate all such requests.

Evaluation Process:
Neuropsychological evaluation in Dr. Ryan's office typically consists of an intake visit, one or more testing sessions, and a feedback meeting. In some instances, a caregiver or family member may be required to participate in a separate interview to establish the patient's level of functioning. Dr. Ryan may adjust this process based on the needs and abilities of the patient.

Payment Policy:
Co-payments and deductibles are due on the date of testing. Dr. Ryan takes checks, cash and credit cards. If paying privately, one-half the estimated amount is due at the intake session and the balance due when testing is completed.

Cancellation:
There will be no charge or penalty for cancellations made 48 hours prior to the appointment.
Repeated cancellations will result in refusal to reschedule.
Late Cancellation: Due to the length of testing appointments, Dr. Ryan reserves the right to charge a fee, up to the cost of the session missed, for failure to cancel or cancellations less than 48 hours prior to the appointment. This fee must be paid prior to rescheduling.

Court Appearance:
Evaluations done under insurance coverage are for medically necessary reasons only. However, at times, the results of Dr. Ryan's evaluation go beyond the patient's care team and lead to court action (guardianship, etc.). If Dr. Ryan is required to appear in court, there will be a base charge of $500. Additional fees may accrue depending on how much time Dr. Ryan is required to spend preparing for court, following up after court, etc. The cost of a court appearance will be determined prior to her appearance and is required to be paid in advance. The Cancellation Policy applies also to court appearances.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Client: _____

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