2448 S 102nd Street, Suite #270 | West Allis, WI 53227
Phone: 414-444-9811 | Toll Free: 866-727-5915 | Fax: 414-444-9822
glassmanneuropsychology.com

To Our Patients:

As a precaution, we moved patient evaluations, or telemed, exclusively online since mid-March 2020. Effective Monday, June 15, 2020, we offer two options: 1) online or 2) in-office with safety measures to control the spread of the coronavirus. Please read the attached Informed Consent for In-Person Services During Covid-19 or go to our website at glassmanneuropsychology.com to determine which service is best for you.

For all appointment types, we request the following:

Information Request – 10 Business Days Prior to Appointment

If we have requested information from you prior to you visit, such as psychological or medical records, a copy of your insurance card, or any letters supporting payment of your evaluation such as in the case of worker's compensation, they must be received 10-days prior to your scheduled appointment or it will be re-scheduled.

Information via Email
Please complete and sign the attached documents:

- Informed Consent for In-Person Services (if you choose this option)
- Patient Registration Form with a **front and back copy** of your insurance card.
- Patient Authorization Form to Release Medical Information.
- Notice of Privacy Practices.
- Receipt of Notice of Privacy Practices.

Payment for Evaluation

We accept checks and all major credit and debit cards. If you are paying through your insurance, we will submit your expenses to our billing service.

Instructions for Online Evaluations

For your online evaluation, we have a few easy instructions to get ready for your meeting with Dr Glassman.

- ✓ Be ready on time – logged on to your email on your laptop or tablet (no cell phones)
- ✓ Watch for the doxy.me link from Dr Glassman to join him in the meeting. As an option you can place this link in your search bar and wait for Dr Glassman to join you: https://doxy.me//drnglassman
- ✓ Be rested
- ✓ Have a beverage and snack available
- ✓ Have paper and a pencil or pen ready to go
- ✓ Be in a quiet, well-lit space

If the patient is under the age of 12, please have a parent or guardian nearby to assist if necessary.

Remember, this new online format **may** extend the time for testing to **2 days**. Testing is either Monday, Wednesday or Friday from 9 a.m. – 2 p.m., with breaks in-between. We will confirm the length of the test when we finalized your new online appointment. Please call if you have any questions or need to re-schedule the testing.

Thank you in advance as we all venture together into this “new normal” – at least for now.

Again, please do not hesitate to contact us if you have any questions or concerns.

Be Well,

Susan Taylor, MS
Office Manager
Glassman Neuropsychology & Associates LLC
414.444.9811

GLASSMAN NEUROPSYCHOLOGY & ASSOCIATES LLC
PATIENT REGISTRATION FORM

(Please Print)

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name: First: Middle:			Marital status: Single Mar Div Sep Wid		
Birth date:	Sex:	Social Security no.:	Phone no.: ( )	Phone no: ( )	
Street address:		City:	State/Zip Code:		
Occupation:	Employer:		Employer phone no.: ( )		
Referral Source:	Phone no:	Reason for referral:			
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )		
Employer:	Employer address:		Employer phone no.: ( )		
Is this patient covered by insurance? Yes No		Preauthorization/Referral: Yes No	Authorization No.:		
Name of primary insurance:	Subscriber's name:	Policy no.:	Phone no.:	Claims address:	

Patient's relationship to subscriber:	Self	Spouse	Child	Other Coverage:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Phone no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I authorize use of this form on all of my insurance submissions and release of information to them.

1. I understand that I am responsible for the full amount of my bill for services provided.
2. I authorize direct payment to my service provider.
3. I hereby permit a copy of this to be used in place of an original.

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance on the day and time service is provided. There will be a $45.00 service charge on all returned checks. In event that your account goes to collections, there may be a 20% collection fee added to your balance.

There is a 24-hour cancellation policy which requires that you cancel your appointment 24 hours in advance between the hours of 8AM to 5PM Monday through Friday to avoid being charged $45.00.

CONSENT TO PSYCHOLOGICAL CARE

I, having legal responsibility and authority and knowing that I am in need of outpatient diagnostic and other similar psychological treatment do authorize Dr. _Nathan Glassman __, his/her assistants or designees to perform and prescribe treatment and such care by Glassman Neuropsychology Associates, LLC, and their staff as deemed advisable under the circumstances. I understand that my psychologist (s) may not be employed by this agency. It is also understood and agreed that at times students under the supervision of authorized agency personnel may deliver services. The arrangements of unemployed psychologists and students are detailed in the HIPAA Notice of Privacy Practices. I authorize __Dr Nathan Glassman & Office Assistant __ to contact my primary care physician _____ regarding information pertaining to psychological and emotional function.

Patient/Guardian signature ***Date***

PATIENT AUTHORIZATION FORM

Patient Name _____Date of Birth _____

1) I understand that I am under no obligation to sign this form
2) the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information cannot make my treatment, evaluation, or payment on my decision to sign this authorization except: when services are to create health information for disclosure to a specified third party (such as, but not limited to, the Division of Vocational Rehabilitation, a referring attorney, a referring physician, and so on).

I authorize:

The following health information to be used/disclosed (check all that apply):

- Neuropsychological Evaluation Results
- Psychological Evaluation Results
- Other: _____

The following person(s)/organization(s) to **use and/or disclose** my health information (write in):

_____

The following person(s)/organization(s) **to receive and/or disclose** my health information (write in):

_____

T

My health information **to be used and/or disclosed** for the following purposes (check all that apply):
Legal purposes
Personal record purposes
Continuity of Care
Other: _____

Right to Revoke Authorization: I understand that I have the right to revoke this authorization at any time and that it must be in writing. To obtain a copy of an authorization revocation form, I must contact Dr Glassman's Office Manager, 2448 South 102nd Street, Suite 270, West Allis, WI 53227, 414-444-9811. I am aware that my revocation will not be effective if: 1) this authorization was obtained as a condition for providing treatment or evaluation; 2) to the extent that the person(s)and/or organization(s) identified above have already acted in reliance upon the authorization.

I understand that organization(s) that are not health care providers or affiliated organizations are not subject to federal privacy standards. As such, my health information disclosed pursuant to this authorization may no longer be protected by federal privacy standards if the recipient(s) are not bound by federal privacy standards. Such person(s) and/or organization(s) may redisclose my health information *without* obtaining my authorization.

I understand that Glassman Neuropsychology Associates, LLC, may receive direct or indirect remuneration in connection with the use and/or disclosure of my health information. Such remuneration is governed by usual and customary fees charged for psychological services or reasonable fees for copying records to release information.

Expiration of authorization: This authorization will be effective until (check one):

- □ A period of six (6) months from the date on which this authorization is signed
- □ A period-of-time necessary to make effective the purpose for which it is given

Patient/Guardian signature ***Date***

Note: Personal representative means patient, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives a deceased patient, an adult member of the deceased patient's immediate family may qualify. A court appointed temporary guardian to consent to the release of records may also qualify.

GLASSMAN NEUROPSYCHOLOGY & ASSOCIATES LLC
NOTICE OF PRIVACY PRACTICES

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.

USE AND DISCLOSURE OF HEALTH INFORMATION: Glassman Neuropsychology Associates LLC, may use your health information, that is information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. We have established a policy to guard against unnecessary disclosure of your health information.

EXAMPLES OF CIRCUMSTANCES IN WHICH HEALTH INFORMATION MAY BE USED AND DISCLOSED:

- To provide treatment
- To obtain payment
- To conduct health care operations

Further information on these uses of health care information is available from Glassman Neuropsychology Associates LLC, at your request.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION: Other than as stated above, Glassman Neuropsychology Associates LLC, will not disclose your health information other than with your written authorization. If you or your representative authorizes Glassman Neuropsychology Associates LLC, to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION: You have the following rights regarding your health information maintained by Glassman Neuropsychology Associates LLC:

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Glassman Neuropsychology Associates LLC's disclosure of your health information to someone who is involved in your care or the payment of your care. However, Glassman Neuropsychology Associates LLC, is not required to agree to your request. If you wish to make a request for restrictions, please contact Office Manager, at 414-444-9811.

Right to Receive Confidential Communications: You have the right to request that Glassman Neuropsychology Associates LLC, communicate with you in a certain

way. For example, you may ask that communications pertaining to your health information be done privately with no other family members present. If you wish to receive confidential communications, please contact Office Manager, at 414-444-981 1.

Right to Inspect and Copy Your Health Information: You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to Office Manager, at 414-444-9811. If you request a copy of your health information, Glassman Neuropsychology Associates LLC, may charge a reasonable fee for copying and assembling costs associated with your request. These costs are $.1.00 per page.

GLASSMAN NEUROPSYCHOLOGY
RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature on this form acknowledges that I have received a copy of Glassman Neuropsychology Associates LLC's, Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Glassman Neuropsychology Associates LLC, and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient/Guardian signature ***Date***

TO BE COMPLETED BY TESTING CLINCIAN IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices?
   □ Yes □ No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of Receipt of Notice of Privacy Practices and explain why the patient was unable or unwilling to sign this form: _____
   _____
   _____
   _____

GLASSMAN NEUROPSYCHOLOGY
INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS (6/3/2020)

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __

- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___

- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in all areas of the office (I [and my staff] will too). ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___

- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient/Client Date

_____ _____

Psychologist Date

GLASSMAN NEUROPSYCHOLOGY
OFFICE SAFETY PRECAUTIONS DURING COVID-19 PANDEMIC

My office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- My office pivoted to seeing patients exclusively online using tele-health in mid-March, thereby reducing the overall exposure to Coronavirus.

Effective June 2020, Glassman Neuropsychology will transition to a hybrid-office/telemed business model including the option for either online or in-office evaluations with health precautions including the following:

- My staff pre-screens patients before making an appointment about exposure risks including travel, group participation or exposure to people with confirmed cases of Coronavirus.
- My staff pre-screens patients on the day of their appointment for symptoms including cough, fever, shortness of breath and other respiratory illness or feeling unwell.
- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- My staff and I wear masks.
- My staff maintains safe distancing, including using plexi-shields when necessary.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Exposure is limited to 45 minutes for any testing requiring 2 people participation.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.

GLASSMAN NEUROPSYCHOLOGY
EVALUATION AND TREATMENT FEE SCHEDULE*

Initial Diagnostic Interview	$250.00 per 45 – 50 Minutes Session
Individual Psychotherapy Session	$190.00 per 45-50 Minutes Session $270.00 per 75-80 Minutes Session
Family Therapy Session	$190.00 per 45-50 Minutes Session
Psychological Evaluation*	$300.00 per 60 Minutes
Neuropsychological Evaluation*	$350.00 per 60 Minutes

**Terms: ***The fees listed are before insurance and/or other forms of payment are taken into consideration. Fees for psychological and neuropsychological *evaluations* vary according to the number and type of tests administered, and the time needed for scoring, interpretation, reporting and consulting on them.

I understand that I am financially responsible for any portion of the bill which will not be covered by my insurance company or other 3rd parties.

I have read and understand this Fee Schedule and its Terms.

Patient/Guardian signature ***Date***

*EFFECTIVE JAN 1 2020