Franklin C. Brown, Ph.D., ABPP

954 Middlesex Turnpike, Suite 4R
Old Saybrook, CT 06475-1302

Phone: (860) 661-2089
Fax: (800) 370-4016

Insurance Information and Billing Authorization

Patient Name _____Date of Birth _____

Marital Status _____ Gender _____ Occupation _____

Address _____

City _____State_____ Zip Code _____

Home Phone _____Work or Cell Phone _____

Social Security Number _____(If patient is child, use parent)

Emergency Contact Name _____Phone _____

If Primary Insured Different than Patient: Patient Relationship to Insured _____

Primary Insured Name _____ Date of Birth _____

Authorization to Bill Insurance or Government, and Financial Responsibility

I authorize the release of relevant medical or other information to process payment for this evaluation. I also request that the government and/or my insurance benefits to pay for this claim. I understand that I am responsible for any co-pays, deductibles, or unpaid balance which is consistent with my insurance/Medicare policy. I also understand that failing to pay remaining balances by their due dates may result in referral to a collection agency and additional fees.

_____ _____

Patient/Parent (if under 18)/ or Responsible Party Signature Date

Information Release

My signature **below** authorizes Dr. Franklin Brown to send the written report or discuss the results of this neuropsychological evaluation to the following people/agencies. I understand that this information will include information from the interview, test results, and may include information about my medical history, mental health history, and substance use (tobacco, alcohol, or other substances). I also understand that I can revoke this authorization at any point in writing, or by verbal request. I also have a right to get a list of those individuals who have received my information at a later point. This is effective for **1 year** from the signed date, unless otherwise indicated here _____.

Release Information to or Receive Information From:

Name 1: _____Phone_____

Address: _____Fax _____

City: _____ State: _____ Zip Code _____

Name 2: _____Phone_____

Address: _____Fax _____

City: _____ State: _____ Zip Code _____

Name3: _____Phone_____

Address: _____Fax _____

City: _____ State: _____ Zip Code _____

_____ _____ _____

Patient/Parent/ or Responsible Party Signature Date Witness Signature/ Printed Name

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Privacy Notification

This notice describes how medical and psychological information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, you may ask Dr. Franklin Brown to address your concerns.

The information that you disclose during your treatment/ evaluation will be maintained as confidential with the exception of the situations described below (in the exception section). Confidential means that only Dr. Brown will have access to your medical information, unless you specifically grant permission to release the information to others.

Limits to Confidentiality

Information **can only** be released without your consent for billing purposes, referrals to other providers, and authorities in the event of child or elder abuse, or intent to seriously harm.

Release of de-identified information

In some cases, some aspects of your medical or neuropsychological records may be released for research or for reasons of public health statistics. If this is the case, **ALL** personally identifiable information will be **removed** from the records to ensure that the information can not be traced back to you.

Right to Access and/or Amend Your Records

You have a right to look at or get a copy of your neuropsychological report and most forms of other medical records. However, there may be legal limits that may not permit you to review raw test data (such as look at your raw scores and answers). In rare instances it may also be determined that release of certain information may not be helpful, in such cases this will be explained to you verbally and in writing. If you wish to add or request an addendum to a report, you may request this in writing. However, any such changes would only be made if clinically/medically appropriate at the discretion of Dr. Brown. Records more than 7 years old will be shredded and discarded.

Right to an Accounting

You have a right to request a list of instances where disclosures of your health information were made within the past six years.

Right to Copy of this Notice

You have a right to request a copy of this notice.

My signature indicates that I understand the above privacy policies.

_____ _____
Patient /Parent/ or Representative Printed Name Date

_____ _____
Patient/Parent (if under 18)/ or Responsible Party Signature Date