Michael P. Santa Maria, Ph. D.
Board-Certified Neuropsychologist; Diplomate, Clinical Neuropsychology (ABPP-CN)
1825 Maple Road, Suite 200
Williamsville, NY 14221
Phone (716) 687-8748
Fax (716) 687-8753

A confirmation call will be made to the phone number provided to us 2-3 days prior to your appointment. All appointments must be confirmed by you or, per policy, the appointment will automatically be cancelled. If your telephone number changes, please contact our office immediately to notify us of the change.

Please read this entire page in order to be prepared for your evaluation.

- For neuropsychological evaluation and testing, you can expect your appointment to take **between 4 and 7 hours**. **You will be allowed breaks and a 30-minute lunch. Feel free to bring snacks/drink/lunch.**

- Spinal cord stimulator or pain pump implant candidate pre-evaluation, pain management evaluation, or bariatric surgery candidate evaluation **–- 2-3 hrs**.

- For an interview only (usually for insurance purposes to acquire prior authorization), your visit will be **approximately 1 hour**.

Please bring the following*:*

- Insurance referral form/prior authorization number(s) (if required) or script from referring physician
- **Insurance card and/or pertinent insurance information (Workers Compensation/No-Fault, etc.)**
- **Driver license, passport or other photo identification.**
- **Co-pay, if applicable, is due at time of visit(s). We accept cash, check or money order only** (checks should be made out to "Neuropsychology and Psychology Services")**. Sorry, no credit cards.** ***NOTE:*** *Most insurance plans charge a co-pay for the testing date* ***and*** *the return/follow-up date for the results.*
- **Glasses and/or hearing aid, if needed.**
- Any copies of medical records, or head CT or MRI reports which you may have on hand.
- **The enclosed paperwork, completed and signed should be brought with you at time of visit.**

****If the patient is on medication for an attention deficit (ADHD), please do not have the patient take the medication the morning of the testing. You should bring the medication with you in case it should become necessary later in the day.**

Thank You.

PATIENT INFORMATION

Sex: Marital Status

PATIENT: _____ Female____ Male____ _____

ADDRESS: _____ DATE OF BIRTH: ____/____/____ SS#_____ _____

CITY/STATE/ZIP: _____ HOME PHONE: _____

PRIMARY CARE PHYSICIAN: _____Phone #: _____

REFERRING PHYSICIAN: _____ Phone #: _____

WORK PHONE: _____ HIGHEST EDUCATION LEVEL COMPLETED: _____

If patient is a child or has a guardian, provide name of parent(s) or legal guardian: _____

relationship _____ Address _____

Phone: _____Work Phone _____Cell _____

Is this visit covered by one of the following? If so, circle the applicable choice.

WORKERS' COMP NO-FAULT DISABILITY INSURANCE

If you <u>did not</u> circle one of these, proceed to the Health Insurance section below.
If you <u>did</u> circle one of the above, complete this section <u>and</u> the Health Insurance section below.

CARRIER CLAIM #: _____ Date of Injury: _____Workers' Comp Board # (if applicable): _____

Name of insurance carrier: _____ Carrier or adjuster's phone number: _____

Carrier address: _____

ATTORNEY (IF RECORDS SHOULD BE SENT TO HER/HIM): _____ Phone: _____

Full Address_____ Your signature authorizing release: _____

PRIMARY HEALTH INSURANCE (complete this section even if this is a workers' comp or no fault case):

____ Blue Cross/Blue Shield
____ Child Health Plus
____ Family Health Plus
____ Nova
____ GHI
____ Empire
____ Independent Health
____ Independent Health Medisource
____ Medicaid
____ Medicare
____ Railroad Medicare
____ Tricare
____ Univera
____ Univera Senior Choice
____ Other _____

ID Number: _____ Group _____ Policy Holder _____ SS# _____

Policy holder's Employer: _____ Patient's relationship to policy holder: ____SELF ____SPOUSE ___CHILD _OTHER

SECONDARY HEALTH INSURANCE:

____ Blue Cross/Blue Shield
____ Community Blue
____ CB Child Health Plus
____ CB Family Health Plus
____ Empire
____ GHI
____ Independent Health
____ Independent Health Medisource
____ Medicaid
____ Medicare
____ Nova
____ Railroad Medicare
____ Tricare
____ Univera
____ Univera Senior Choice
___ Other _____

ID Number: _____Group _____ Policy Holder _____ SS# _____

Policy holder's Employer: _____ Patient's relationship to policy holder: ____SELF ___SPOUSE ___CHILD ___OTHER

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM (S). I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Neuropsychology and Psychology Services, P.C., for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents (in the case of Medicare) or to my agency or insurer any information needed to determine these benefits or the benefits payable to related services. This also applies to Workers Compensation claims, where health information may be exchanged with the insurance carrier and the Workers Compensation Board. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of information to the agency or insurer shown.

_____ _____

(SIGNATURE OF LEGALLY RESPONSIBLE PARTY) (DATE)

MICHAEL P. SANTA MARIA, PH.D.

BILLING POLICY

- This office participates with numerous insurance companies and accepts assignment from many. It is your responsibility to provide us with accurate and sufficient billing information to determine whether our services are covered by your insurance contract. You can check coverage and receive answers to questions regarding your policy by calling the telephone number on the back of your insurance card.

- If your insurance company requires that you have a referral for services rendered in this office, it is your responsibility to obtain that referral and present it at the time of treatment. If you fail to obtain that referral, resulting in the denial of our claim by your insurance company, you will be responsible for payment for services billed. **You are also responsible for co-payments, deductibles, etc. as determined by your insurance company. A $5.00 billing fee will be charged to all accounts with outstanding co-pays, billed each time after 30 days.**

- If we do not participate with your insurance or if you do not have insurance, payment in full is expected at the time of your visit.

- If No Fault or Workers' Compensation is your primary insurance for this visit, you are responsible for providing us with accurate information regarding the insurance carrier's name and address, the date of the injury, WBC# and Carrier Case number. If your insurance carrier denies payment, all outstanding balances are your responsibility unless you have a personal health insurance that covers those services rendered.

- If we receive a payment denial of our claim(s) from your insurance company or other contracted payor of services, you will be responsible for payment.

- Note: Responding to Forensic/Medical Legal requests, conferences and telephone calls with attorneys involve additional time and record keeping. The Responsible Party is responsible for all direct costs and expenses associated with Dr. Michael P. Santa Maria and attorney(s) responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to, court appearances, preparation of reports, photocopying, faxes, long-distance telephone calls, out of office travel, overnight delivery and courier services. These expenses are billed to the Responsible Party and to the Patient's/Responsible Party's Attorney. The Responsible Party, however, remains responsible for payment of these charges if not paid in full within sixty (60) days. The above noted direct cost and expenses are understood and accepted to be in addition to any published federal and/or state statutes, which may otherwise apply.

- ***CANCELLATION FEE:*** **Unless a testing appointment is cancelled more than 24 hours in advance, there will be a cancellation charge of $150 to the Responsible Party. This is due to the large block of time set aside for testing.**

I have read the above billing policy of this office and my agreement to abide by its terms is signified by my signature.

Patient's Name
(printed)_____

Patient's Signature: _____Date:_____

Witness Signature: _____Date:_____

For Office Use Only:

- ❑ Insurance information verified
- ❑ **Card(s) copied**
- ❑ **Co-pay paid $_____**

MICHAEL P. SANTA MARIA, PH.D.

PRIVACY NOTICE

We understand our patients' rights to privacy and confidentiality with regard to their medical records. We have a policy of keeping your medical records and other information received from you and your health care providers confidential. We pledge to protect your medical records in accordance with federal and state privacy laws. This notice provides information on how we protect your personal health and financial information.

Protected Health Information

We in this office are committed to safeguarding your protected health information (**PHI**) in accordance with applicable state and federal laws, rules and regulations. We protect this information from improper disclosure through staff training, by limiting staff access to only those records necessary for proper completion of required tasks, by securing our buildings and computer systems, and by entering into agreements with business partners that include confidentiality promises and safeguards.

Disclosure of Protected Health Information

The following outlines various circumstances under which we may disclose your PHI:

- For Treatment: We may disclose your PHI to physicians and medical personnel and staff in the office that has referred you to this office to obtain necessary information for your care and to appraise them of the results of your evaluation and to provide them with a basis and recommendations for your continued care.
- For Payment: We may disclose you PHI to your insurance company in order to bill for services rendered, to obtain authorization from your insurance company, to collect on claims filed, to sort out coordination of benefits when more than one insurance is thought to be involved and/or to any individual or entity involved in the payment of or the securing of payment of your medical bills.
- As Required by Law: We may disclose PHI when required by federal, state, or local law to do so, i.e., by the courts, health oversight bodies, or other entity which has legal jurisdiction regarding such.
- To a Parent or Guardian: We may disclose the PHI of a child under the age of eighteen to a parent, guardian, or person with similar legal status as allowed or required by New York State law.
- In Case of Victim Abuse: We may disclose your PHI to notify the appropriate authority in the case of abuse or neglect when required by law.
- Inmates: We may disclose the PHI of an inmate to correctional institutions or law enforcement officials for the health, safety or security of the inmate, the institution or other individuals.
- Workers' Compensation: We may disclose your PHI to the extent necessary to comply with workers' compensation laws.
- Research: Under certain circumstances we may disclose your PHI for research purposes. In research situations your medical information may be reviewed to determine suitability for the research project. In this case, the PHI does not leave our office and is not further used by the researcher unless chosen for the study, at which time we would ask for your permission for its use and identifying information would not be shared. In these instances, our agreements with these researchers or other providers require that the information we disclose be used for a limited, well-defined purpose and that it be appropriately safeguarded.

Your Rights

You have the right to request any of the following: (a) a paper copy of this disclosure, (b) an appointment to review your PHI, (c) a change to your PHI if you feel it is incorrect or incomplete, (d) an accounting of non-treatment disclosures (disclosed after April 14, 2003, and for a stated time period of not longer than six years). Any request should be made *in writing* to **Privacy Officer, Neuropsychology & Psychology Services, PC, 1825 Maple Road, Suite 200, Williamsville, NY 14221.** Your written request should be specific and in the case of item (c) above include supporting reasons for your request for amendment. There may exist certain limited circumstances where a request may be denied.

For requests to disclose your personal health information that are not identified in this Privacy Notice, not permitted under applicable state and federal laws, rules and regulations and are not in the regular course of our business, we ask for and receive your written authorization before any information is disclosed. Such authorization may be revoked by you at any time *in writing*; however disclosures already made can not be rescinded.

The undersigned acknowledges that he/she has read the foregoing Privacy Notice. _____

(Signature of patient or legal representative of patient)

Print patient's name on the following line. _____

Confidential Background Information Form

Patient Name: ________________________________ **Date:** ______________

Referred by: ____________________________, ___

Date of birth: ______/______/______

Race: **Caucasian** **African-American** **Hispanic** **Asian** **Native American** **Other**

Sex: **Female** **Male**

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Have you ever had any of the following procedures? Please circle yes or no:

Procedure	Yes or No?		If so, about when?	If so, where?
EEG (electoencephalogram)	Yes	No	______________________	______________
CAT scan (CT) of the brain/head	Yes	No	______________________	______________
MRI of the brain/head	Yes	No	______________________	______________

Please list **current medications**, dosages, and frequency:

	Medication	Dosage	How Often?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Have you ever had any of the following? (Please circle) **If yes, when was condition first apparent?**

Yes	No	Head injury with loss of consciousness	_____
Yes	No	Seizures	_____
Yes	No	Stroke	_____
Yes	No	Tumor or cancer	_____
Yes	No	Heart attack	_____
Yes	No	High blood pressure (hypertension)	_____
Yes	No	High cholesterol	_____
Yes	No	Diabetes	_____
Yes	No	Thyroid condition	_____
Yes	No	Incontinence	_____
Yes	No	Asthma	_____
Yes	No	Emphysema	_____
Yes	No	Liver disease	_____
Yes	No	Sleep Apnea	_____
Yes	No	Alcohol abuse	_____
Yes	No	Drug abuse	_____
Yes	No	Prescription medication abuse	_____
Yes	No	Cigarette smoking/chew/vaping/e-cigs	_____

Other medical conditions: _____

_____

Have you had any of the following surgeries? **If so, when?** **What Hospital?**

Yes	No	Neurosurgery/brain surgery	_____|_____
Yes	No	Back/spinal surgery	_____|_____
Yes	No	Heart surgery/bypass surgery	_____|_____
Yes	No	Carotid artery surgery	_____|_____

Please provide information about any inpatient treatment for mental health or alcohol/drug abuse:

Name of Hospital/Clinic	**When were you hospitalized?**	**For how long?**	**Reason**
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please provide information about any outpatient psychiatric treatment, psychotherapy, or counseling:

Name of Therapist	**Name of Hospital or Treatment Center**	**Month & Year that Therapy Began**	**Month & Year that Therapy Ended**	**How Often?**	**Reason**
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

City of birth_____

Is your mother living? Yes No
If yes, is she in good health? Yes No
Is your father living? Yes No
If yes, is he in good health? Yes No

How many sisters do you have? Living _____ Deceased _____ Any half-sisters? _____
# of sisters with same mother and father? _____ # sharing mom only? _____ # sharing dad only? _____
How many brothers do you have? Living _____ Deceased _____ Any half-brothers? _____
# of brother with same mother and father? _____ # sharing mom only? _____ # sharing dad only? _____

How many years of education have you completed? _____
If applicable, list high schools attended: _____
If applicable, list colleges attended: _____
Degree or number of semesters? _____
Ever enrolled in special education? Yes No
If so, beginning in which grade? _____
Ever held back a grade in school? Yes No
If so, which grades? _____

Ever served in the military? Yes No
Combat experience? Yes No
If so, branch of service: Army Navy Air Force Marines Coast Guard
Which years you were in the service? _____
Type of discharge? _____

Are you presently employed? Yes No
If no, why not? _____

Past two jobs you have held: **Indicate if Full Time or Part Time**

	Employer	Job Title	Dates Employed	Reason for Leaving	Full or Part Time
1.					
2.					

Any other sources of income?: Social Security Workers' Comp Pension Alimony Social Services

What city or town do you live in presently? _____
Marital Status: Single Married Separated Divorced Widowed

Number of marriages: None 1 2 3 Other: _____
If married, in what year were you married? _____
If divorced or separated, in what year? _____

Below, please list your children including their ages:

	Sex	Age	Name
1.			
2.			
3.			
4.			
5.			

Presently, with whom do you live? _____

Ever been arrested?	Yes	No	When? _____
DWI? DUI? DWAI?	Yes	No	When? _____
Prison time?	Yes	No	When? _____
Currently on probation?	Yes	No	Since when? _____
Currently on parole?	Yes	No	Since when? _____

Are you able to do the following on your own?

Shower/take a bath	Yes	No
Get dressed	Yes	No
Cook simple meals	Yes	No
Laundry	Yes	No
Housecleaning	Yes	No
Take medications	Yes	No
Grocery shopping	Yes	No
Pay bills	Yes	No
Manage a bank account	Yes	No
Drive a car	Yes	No

Comments: _____

Which of the following do you like to do for fun? (circle all that apply):

Watch TV	Sewing	Spend time with family	Automotive
Listen to music	Arts & crafts	Casino/Gambling	Camping
Video games	Gardening	Shopping	Fishing
Walking	Bike riding	Travel	Hunting
Football	Baseball	Volunteer work	Reading
Basketball	Hockey	Others:_____	

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(HIPAA COMPLIANT, FERPA COMPLIANT)

_____ Date of birth _____/_____/_____
(Print patient's name)

hereby authorizes the following entities and/or individual providers to release records and/or exchange information with the other:

Name: **Michael P. Santa Maria, Ph. D.**
Address: **1825 Maple Road, Suite 200**
City, State, Zip: **Williamsville, NY 14221**

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ (if known)
Fax: _____ (if known)

Such release shall include any medical, health, psychological, educational or other school records or other information relevant to my evaluation, diagnosis, treatment and/or care.

I give my permission for the information listed above to be released to the above named requestor. I understand that I may inspect or copy the information to be disclosed. I understand that I may revoke this authorization at any time by requesting this revocation in writing. I understand a revocation will not apply to information already released or to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization.

X_____ _____ _____
Signature of patient or legal representative | Relationship to patient, if not self | Date

X_____ _____
Signature of adult witness (member of office or school staff) | Date

Information being requested at this time: Please **fax** any of the following you may have available.

____ MRI reports of head/ brain, all dates
____CT reports of head/ brain, all dates
____ EEG report
____ Laboratory studies / bloodwork
____ Most recent note/report
____ MRI or CT of _____
____Ambulance/EMT reports

____ Operative Report
____ Admit note or history
____ Discharge Summary
____ Individual Education Program (IEP) or 504 Plan
____ Latest report period grades
____ Attendance Records
____ Psychological reports, impressions

Thank you!

Other_____

_____ Patient is in our office at this time **_____ Request date** **_____ Received**
_____ Second request

Copays are due at time of check in.

We accept cash/check or money orders only.

For your convenience there is an ATM located across the street at the Speedway gas station/Tim Hortons.

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