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.**

- 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.**

- For a child/adolescent (age 21 and under) --
  VERY IMPORTANT!! Please send the signed school release(s) to our office PRIOR to your child's appointment. A self-addressed envelope has been enclosed. Please return ASAP. Release found on next page.

****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.

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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**

School District/
School 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
_X__ Individual Education Program (IEP) or 504 Plan
_X__ Latest report period grades
_X__ Attendance Records
_X__ Psychological reports, impressions

Thank you!

Other: **Teacher report form to be faxed to school by Doctor's office/PLEASE FILL IN AND FAX BACK WITHIN 7 DAYS… THANK YOU!**

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

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	____ Empire	____ Railroad Medicare
____ Child Health Plus	____ Independent Health	____ Tricare
____ Family Health Plus	____ Independent Health Medisource	____ Univera
____ Nova	____ Medicaid	____ Univera Senior Choice
____ GHI	____ Medicare	____ 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	____ GHI	____ Nova
____ Community Blue	____ Independent Health	____ Railroad Medicare
____ CB Child Health Plus	____ Independent Health Medisource	____ Tricare
____ CB Family Health Plus	____ Medicaid	____ Univera
____ Empire	____ Medicare	____ 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

Child's Name: ____ Date: _____________________

Referred by: ____, ___

Date of birth: _______/______/_______

Race: Caucasian African-American Hispanic Asian Native American Other
Sex: Female Male

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~~~~~~

Family History and Structure:
Child's mother's full name: ___________________________
Mother's occupation: ___________________________
Mother's educational background: ___________________________

Child's father's full name: ___________________________
Father's occupation: ___________________________
Father's educational background: ___________________________

Stepparents (if applicable)
Child's stepmother's full name: ___________________________
Stepmother's occupation: ___________________________
Stepmother's educational background: ___________________________

Child's stepfather's full name: ___________________________
Stepfather's occupation: ___________________________
Stepfather's educational background: ___________________________

Did any parent have any of the following when in school? Please circle all that apply and please indicate whether difficulties were had by child's mother and/or father:

Repeat a grade Speech therapy Resource room
Problems with math Problems with spelling Problems with reading
Other: ____

Parents are (circle all that apply):

Married to each other — If married, in what year? _________
Separated — If separated, in what year? _______
Divorced — If divorced, in what year? ________
Never Married to each other
Mother is married to someone other than child's biological father — If so, in what year? _____
Father is married to someone other than child's biological mother — If so, in what year? _____
Other: ____

Please list child's brothers and sisters:

Name	*Age*	*Sex*	*Any significant medical/psych/learning problems?*

Are any of the siblings half-siblings or step-siblings? If yes, please give details:

____
____

Was child adopted? Yes No
If yes, at what age did child first come into care of adoptive parents? _________________
City of child's birth: ____
City child presently lives in: ____
With whom does child presently live? ____

Has child ever been in foster care? Yes No
Has Child Protective Services ever been called regarding child? Yes No
~~~~~~

~~~~~~
Does anyone in the family have? Please indicate whether relatives are on mother's or father's side.

Learning disorder? Yes No
If yes, relationship to child: ____
ADHD? Yes No
If yes, relationship to child: ____
Psychiatric Illness? Yes No
If yes, relationship to child: ____
Seizures? Yes No
If yes, relationship to child: ____
Alcohol or drug abuse? Yes No
If yes, relationship to child: ____

Developmental History:

What was the age of mother at child's birth: _____
Has mother ever had a miscarriage? Yes No
If yes, how many miscarriages total? _____
If yes, how many miscarriages before child was born? _____
Child's birth weight: _____
Child's height at birth: _____
Please list any medications or substances mother used during pregnancy: _____
Was child born premature? Yes No
Comments: _____
Any problems during pregnancy with this child? Yes No
If yes, please explain: _____
Were any of the following used in or after the birthing process? Circle any that apply.

C-Section	Forceps	Suction
Lack of oxygen or bluish coloration of baby	Rotation of Fetus	Respirator/Ventilator
Incubation	Apnea Monitor	Other: _____

How many days after birth was child discharged from hospital? _____

At about what age did child first:
Sit up: _____
Say first words: _____
Walk: _____
First speak in sentences: _____
Become toilet trained: _____
Recite ABCs: _____
Tie shoes: _____
Ride a bicycle without training wheels: _____

Medical/Psychiatric History:

Please provide information about any **medical hospitalizations:**

Name of Hospital/Clinic	When were you hospitalized?	For how long?	Reason
Example: Buffalo General	*April & May, 2001*	*2 days*	*knee surgery*
1.			
2.			
3.			

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
Example: Children's Hosp.	*April & May, 2001*	*6 days*	*depression*
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
Ex.: Dr. Logan	*ECMC*	*January, 2000*	*May, 2000*	*weekly*	*anxiety*
1.					
2.					
3.					

Has child ever had prior psychological or academic testing? Yes No

If yes, when? _____

If yes, where? _____

Has child ever had any of the following?

Yes	No	Chicken pox
Yes	No	Measles
Yes	No	Mumps
Yes	No	Frequent ear infections
Yes	No	Head injury with loss of consciousness
Yes	No	Seizures
Yes	No	Tics or other uncontrolled movements
Yes	No	Tumor or cancer
Yes	No	Heart problems
Yes	No	Asthma
Yes	No	Vision problems
Yes	No	Hearing problems
Yes	No	Bedwetting beyond typical age
Yes	No	Depression
Yes	No	Anxiety or nervousness
Yes	No	Sleep problems
Yes	No	Eating or appetite problems
Yes	No	Alcohol use
Yes	No	Drug use
Yes	No	Tobacco use
Yes	No	Cigarette smoking/chew/vaping/e-cigs

Please list any allergies child has: _____

Please list any surgeries child has had: _____

Please list any other medical or mental health concerns regarding child:

_____

_____

_____

Has child ever had any of the following procedures? Please circle yes or no:

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

Please list child's **current** medications, dosages, and frequency:

Medication	Dosage	How Often?
Ex: Paxil	*20 mg*	*once a day*
1.		
2.		
3.		
4.		
5.		
6.		

Please list child's **past** medications:

1. _____
2. _____
3. _____
4. _____

Academic History:

Was child enrolled in a Head Start program? Yes No
If yes, at what ages? _____
Has child attended a daycare program? Yes No
If yes, at what ages? _____
If yes, how many days per week? _____

Did child ever have any of the following at any time?

Speech Therapy	Yes No	If yes, at what ages?	_____
Physical Therapy	Yes No	If yes, at what ages?	_____
Occupational Therapy	Yes No	If yes, at what ages?	_____
Special Ed Teacher	Yes No	If yes, at what ages?	_____

Other: _____

Is child currently in school? Yes No
If yes: What grade is child in? _____
Name of school: _____
Name of school district: _____
Child's primary or homeroom teacher: _____
Did child ever repeat a grade? Yes No
If so, which grades? _____

Does child have a 504 Plan? Yes No
Does child have an Individualized Education Program (IEP)? Yes No
Is child in special education classes? Yes No
Does child get any other special services? Yes No
If yes, what services? _____

Is child pursuing one of the following diplomas? Regents Local IEP

How long does it take child to complete homework on an average day? _____
Who usually assists child with homework? _____
Where does child usually do homework? _____

Legal History:

Has child ever been picked up by police or arrested? Yes No
Ever had a PINS (person in need of supervision) warrant? Yes No
Is child currently on Probation? Yes No
If yes, to any the above question, reason: _____

Work History:

Is child presently employed? Yes No

If child has ever been employed, please provide details:

Employer	Job Title	Dates Employed	Reason for Leaving	Full /Part Time
Ex.: Joe's Restaurant	*Chef*	*5/07-6/08*	*got a better job*	*part-time*
1.				
2.				

Social and Interpersonal History:

Please list any extracurricular activities child is involved in:

_____

What other activities does child like to do for fun?

_____

Is child happy with the friends she/he has? Yes No
Comments: _____

Are parents happy with the friends child has? Yes No
Comments: _____

Any additional comments:

CANCELLATION FEE

A cancellation fee of $150.00 will be charged to those who neglect to cancel a neuropsychological testing appointment at least 24 hours in advance of that appointment. This is necessary because of the large block of time (5 to 7 hours) that must be set aside for that evaluation.

IME evaluations will be charged the same said fee if appointment is not cancelled within 72 hours of scheduled appointment.

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.