

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 if needed. 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, money order, or credit card** (checks should be made out to "Neuropsychology and Psychology Services")
WE ONLY ACCEPT VISA OR MASTERCARD.
- **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.**

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

**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.

- | | |
|--|---|
| <input type="checkbox"/> MRI reports of head/ brain, all dates | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> CT reports of head/ brain, all dates | <input type="checkbox"/> Admit note or history |
| <input type="checkbox"/> EEG report | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Laboratory studies / bloodwork | <input checked="" type="checkbox"/> Individual Education Program (IEP) or 504 Plan |
| <input type="checkbox"/> Most recent note/report | <input checked="" type="checkbox"/> Latest report period grades |
| <input type="checkbox"/> MRI or CT of _____ | <input checked="" type="checkbox"/> Attendance Records |
| <input type="checkbox"/> Ambulance/EMT reports | <input checked="" type="checkbox"/> 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 _____ Received
_____ Second request

PATIENT INFORMATION

PATIENT: _____ SEX: Female ___ Male ___ MARITAL STATUS: _____

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 did not circle one of these, proceed to the Health Insurance section below.

If you did circle one of the above, complete this section and 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 \$ _____

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: Provider's name: _____, _____

Date of birth: _____ / _____ / _____

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

Family History and Structure:

Child's Biological Parents

| | |
|----------------------------------|----------------------------------|
| Mother's full name: | Father's full name: |
| Mother's occupation: | Father's occupation: |
| Mother's educational background: | Father's educational background: |

Child's Stepparents (if applicable)

| | |
|--------------------------------------|--------------------------------------|
| Stepmother's full name: | Stepfather's full name: |
| Stepmother's occupation: | Stepfather's occupation: |
| Stepmother's educational background: | Stepfather's educational background: |

Child's Adoptive/Foster Parents/Legal Guardian(s) (if applicable)

| | |
|----------------------------------|----------------------------------|
| Mother's full name: | Father's full name: |
| Mother's occupation: | Father's occupation: |
| Mother's educational background: | Father'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:

| <i>Name</i> | <i>Age</i> | <i>Sex</i> | <i>Any significant medical/psych/learning problems?</i> |
|-------------|------------|------------|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are any of the siblings half-siblings, step-siblings, or adoptive siblings? _____
 If yes, please give details (i.e. 1/2 maternal, 1/2 paternal, step, adoptive, etc.): _____

Has child ever been in foster care? Yes No
Was child adopted? Yes No
 If yes, at what age did child first come into care of adoptive parents? _____
 Where was child placed prior to adoptive parent's care? _____

City of child's birth: _____
City child presently lives in: _____

With whom does child presently live? (If split custody please list with whom the child lives at each residence)

Has Child Protective Services ever been called regarding child? Yes No
 If yes, please explain each instance: _____

| Does anyone in the family have the following? | Circle Yes or No | If yes, please list all applicable relatives and their relationship to the child. (Indicate if mother's or father's side) | If yes, please specify each relative's diagnosis |
|--|-------------------------|--|---|
| Learning Disorder? | Yes No | | |
| ADHD? | Yes No | | |
| Psychiatric Illness? | Yes No | | |
| Seizures? | Yes No | | |
| Alcohol or Drug Abuse? | Yes No | | |

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 | _____ |
| | | If yes, has child had ear tubes placed? | _____ |
| Yes | No | Head injury with loss of consciousness | _____ |
| Yes | No | Seizures: If yes: | _____ |
| | | Type (convulsive/nonconvulsive): | _____ |
| | | Ages (started and stopped)/Total #: | _____ |
| | | Any loss of bladder/bowel control?: | _____ |
| 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 | Start Date | Prescribing Physician | Dosage | How Often? |
|------------|------------|-----------------------|--------|------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

Please list child's past medications:

| Medication | Start Date | End Date | Dosage | Prescribing Physician |
|-------------------|-------------------|-----------------|---------------|------------------------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Academic History:

Was child enrolled in a Head Start program? Yes No

If yes, where? _____

If yes, at what ages? _____

Has child attended a daycare program? Yes No

If yes, where? _____

If yes, at what ages? _____

If yes, how many days per week? _____

| Did the child ever have any of the following at any time? | Circle Yes or No | If yes, at what ages/grades did child receive these services? | Where did/does child receive these services? |
|--|-------------------------|--|---|
| Speech Therapy | Yes No | | |
| Physical Therapy | Yes No | | |
| Occupational Therapy | Yes No | | |
| Special Ed Teacher | Yes No | | |
| Please list any other services child receives: | | | |

Is child currently in school? Yes No (If yes, please fill out table below)

| | |
|---|--------|
| What grade is child in? | |
| Did child ever repeat a grade? (If so, which grades?) | |
| Name of School: | |
| Name of School District: | |
| Name of child's primary or homeroom teacher: | |
| 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 or accommodations? | |

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:

| <u>Employer</u> | <u>Job Title</u> | <u>Dates Employed</u> | <u>Reason for Leaving</u> | <u>Full /Part Time</u> |
|--|------------------|-----------------------|---------------------------|------------------------|
| <i>Ex.: Joe's Restaurant</i> | <i>Chef</i> | <i>5/07-6/08</i> | <i>got a better job</i> | <i>part-time</i> |
| 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?

Does child have one or more friends? Yes No

Comments: _____

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:

Copays are due at time of check in.

We accept cash/check/credit card or money orders. We only accept Visa and Mastercard.

Please note there is a 3% fee for credit cards