SCNEURO
W. Howard Buddin Jr., Ph.D.
Neuropsychologist | Licensed Clinical Psychologist

PATIENT REGISTRATION

Patient's Name: _____ Maiden Name: _____

Date of birth: ___/___/___ Age: _____ Gender: _____ Marital Status: _____

Phone: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Emergency Contact

Name: _____

Address: _____

Phone: _____

Account Guarantor

Relationship to patient (if "self," you may skip the rest of this section):
☐ Self
☐ Other (please describe):

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____ Phone: _____

For child and adolescent patients, please complete the following:

Mother
Name: _____
Phone: _____

Father
Name: _____
Phone: _____

Referred to SC Neuro by: _____

29 Leinbach Dr, Suite D4
Charleston, SC 29407
Phone: 843.509.6521 | Fax: 843.636.3406
www.scneuro.com

Some insurance carriers require the following information for payment processing. Please select ONE choice from each of the categories below:

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other ☐ Declined

Relationship To Insured:

☐ Spouse ☐ Child ☐ Significant Other ☐ Self
☐ Mother ☐ Father ☐ Life Partner ☐ Grandfather or Grandmother
☐ Grandson or Granddaughter ☐ Nephew or Niece ☐ Adopted Child ☐ Foster Child
☐ Stepson or Stepdaughter ☐ Handicapped or Dependent ☐ Dependent or a Minor of Dependent ☐ Employee
☐ Organ Donor ☐ Cadaver Donor ☐ Emancipated Minor ☐ Injured Plaintiff
☐ Child Where Insured Has No Financial Responsibility ☐ Ward ☐ Other ☐ Unknown

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OFFICE POLICY

At SC Neuro, we love what we do, and our goal is to deliver the most efficient, complete care that is available, anywhere. We will discuss assessment and possible treatment options during today's appointment, as well as associated costs and fees. This office policy details some of these issues. Please ask about anything that is unclear.

Insurance, Fees, and Payments

We will pre-certify your benefits and estimate costs in advance of your appointment(s). Please note that we provide an estimate, and not a guarantee. We will also submit your insurance claims for each appointment. We will not, however, negotiate on your behalf after your insurance carrier issues payment. Please note that as of September 2024, we only accept (most forms of) Medicare insurance. If you have a secondary insurance plan for coverage of co-insurances and co-pays, those secondary insurance carriers are automatically billed when we submit claims to Medicare.

Please be prepared to pay the estimated charges for your appointment(s). Any payment for your care, including co-pays, deductibles, and non-covered services, is *due on the day of your appointment*. If your insurance company does not pay *you are responsible for payment in full*. Payments can be made with cash, personal check, and debit and credit cards. Checks should be written to SC Neuro. Please note that there will be a $20.00 service charge on all returned checks. We encourage you to contact your insurance company to verify your coverage and determine the limits of your coverage.

Missed or cancelled (with fewer than 24 business hours advance notice) interview or feedback appointments are subject to a $100 fee. We charge a fee of $200 for missed or cancelled testing appointments. These charges are neither billed to, nor covered by, your insurance carrier.

Scheduling & Appointments

Reserving time for your particular needs is our priority. Please be aware that your appointments will begin and end according to the scheduled time. We cannot add time if you arrive late. In the event of a late arrival, you will be charged for the full clinical hour. Please give us at least 24 business hours' notice if you must cancel or change an appointment. This courtesy makes it possible for us to give your time to someone else in need. Repeated cancellations or missed appointments might result in loss of future appointment privileges. Lastly, we will not schedule you for another appointment if you twice cancel, reschedule, or miss your assessment/testing appointment.

For Divorced Parents of Children who are Patients

The custodial parent is always legally responsible for the entire evaluation fee without regard to divorce decree or any separate agreement that might exist. There is no situation where splitting the fee or making two financial arrangements for one fee is acceptable or appropriate. The custodial parent must always provide documentation to the fact that they are (a) the custodial parent and (b) legally responsible for medical, mental health, and/or psychiatric healthcare decision-making. If you do not have this documentation with you, we will not see your child and we will have to reschedule the appointment.

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Forensic/Legal Involvement

Please let us know, as early as possible, if you are involved in any sort of litigation, as it can have a significant impact on many aspects of the evaluation process, including cancellation of future appointments. Dr. Buddin works only as an expert witness in forensic/medicolegal cases, not as a fact witness. Please ask if you are not sure about what this means.

Confidentiality & Office Procedures

Information regarding treatment will not be released unless there is written consent from the patient or the patient's legal guardian or caregiver. Information can be released *without consent or assent* (assent is consent that is spoken) in the following cases: indication that immediate danger to self or others exists; a court order that directs the release of information; disclosure of sexual abuse, physical abuse and/or neglect of a child under the age of 18. If this evaluation is being conducted as part of legal proceedings, confidentiality may not apply, as information will be released to your attorney and may be discussed as part of a deposition and/or courtroom proceedings.

I authorize the following person(s) to obtain medical and/or financial information about me or my child.

Name: _____

Relationship: _____

Phone: _____

Communication Between Patient/Caregiver and Our Office

You have the right to request and have our office communicate with you by alternative means. For example, we can accommodate your request to receive appointment reminders by text or phone or send a link to your evaluation report and billing statements by e-mail. Email is an *unencrypted* form of communication. This means that W. Howard Buddin Jr., Ph.D./ South Carolina Neuropsychology, LLC (SC Neuro) have implemented policies and procedures to restrict access to, protect the integrity of, and guard against unauthorized access to electronic Personal Health Information (e-PHI). If you would like, we can send you a link to download an encrypted version of your report and other medical records containing your PHI.

Please choose one of the following:

☐ I understand the risks of using email to send and/or receive my PHI and do hereby give W. Howard Buddin Jr., Ph.D./SC Neuro permission to communicate with me via email.

NOTE: Please *do not* give an email address associated with your employer/job/school. Please give only a personal email address (such as @gmail, @hotmail, @yahoo, etc.)

Email address: _____

☐ Please use the United States Postal Service to send my report and/or anything with my PHI.

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ACKNOWLEDGMENT, AGREEMENT, AND CONSENT

I agree to have Dr. Buddin perform neuropsychological and/or psychological testing, psychotherapy, and/or related mental health treatments, but I may at any time decline specific recommendations. I also agree to allow Dr. Buddin to consult with other professionals deemed appropriate and necessary in providing quality care. Patients can file inquiries with the South Carolina Board of Examiners in Psychology. The Board of Examiners in Psychology offices may be reached at:

SC Board of Examiners in Psychology
P.O. Box 11329
Columbia, SC 29211-1329

I assign all insurance benefits, if any, otherwise payable to SC Neuro for services rendered. I understand that I am ultimately responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize Dr. Buddin to release relevant/necessary information to my insurance company and the professional who referred me (or my child). This information is protected under the HIPPA Privacy Act. I have read the information stated above and I am in agreement with the policies and procedures as presented.

I acknowledge that I have received the HIPAA notice of Privacy Practices and Patient Services Agreement from W. Howard Buddin Jr., Ph.D./South Carolina Neuropsychology, LLC (SC Neuro).

I have read all information above, and I am in agreement with the policies and procedures as presented.

Signature (Patient/Guarantor or Parent/Guarantor)	Relationship to patient if other than self
Print Patient's name	Date

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