



**Michelle Papka, Ph.D.**

**Psychologist**

*Specializing in Neuropsychology and Psychotherapy*

Dear Patient:

Enclosed please find the following documents:

New Patient Information Sheet  
Fees and Payment Policies  
Self-Report Questionnaire  
Authorization Form  
Acknowledgement of Notice  
New Jersey Notice Form

Please complete the packet and return it in the envelope provided or bring it with you to your first appointment. Please read the Fees and Payment Policies carefully. Deposit checks in the amount specified or credit card authorization is required prior or at the time of the first visit. Please also include in this packet any relevant medical records or arrange to have them faxed to Dr. Papka's attention at 908-522-6147.

If you have any questions or need assistance completing this packet, please do not hesitate to call my office. Once we have received your completed packet, we will contact you to set up an appointment.

Thank you for allowing me to participate in your care.

Sincerely,

Michelle Papka, Ph.D.



**Michelle Papka, Ph.D.**

**Psychologist**

*Specializing in Neuropsychology and Psychotherapy*

New Patient Information Sheet

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## **New Patient Information Sheet**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Handedness: \_\_\_\_\_ Right handed \_\_\_\_\_ Left Handed \_\_\_\_\_ Ambidextrous

SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Name (if Different than Patient):** \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Referring Physician (Name and Specialty), if applicable:** \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Insurance Information**

Primary Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**Secondary Insurance**

Secondary Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Please provide copies of your insurance cards (front and back) or bring them to the first scheduled appointment so that we may make copies.

**Medicare Authorization and Release:**

If Medicare is your primary insurance carrier, we will bill Medicare on your behalf. In order for us to do so, you must sign the authorization below:

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Dr. Michelle Papka for services provided.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

**Payment Method/Credit Card Authorization:**

Please read the Fees and Payment Policies agreement carefully and contact the office with any questions before signing. Please note, that we prefer credit card authorization to a check especially for Medicare patients, since the billing amount can vary and credit card payment simplifies the billing process. **If Medicare is your primary insurance carrier**, you must enclose a deposit check made out to Dr. Michelle Papka in the amount of \$262.43 or provide credit card information/authorization below. **If Medicare is NOT your primary insurance carrier**, you must enclose a deposit check of \$700, or provide credit card information/authorization below.

\_\_\_ deposit check enclosed; additional checks will be collected as detailed in the Fees and Payment Policies Agreement.

\_\_\_ I authorize Dr. Michelle Papka to charge the credit card below for any unpaid balances for services rendered. Charges will correspond to amounts detailed in the Fees and Payment Policies Agreement. This authorization shall remain in effect until terminated by me in writing.

Card Type: \_\_\_ Visa \_\_\_ Mastercard \_\_\_ American Express \_\_\_ Discover

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

3-Digit Security Code: \_\_\_\_\_ (on back of card)

Signature of Cardholder: \_\_\_\_\_ Date: \_\_\_\_\_

**Card Holder Name and contact information (if different than patient):**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Billing address (please include city, state and zip code): \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_



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Fees and Payment Policies

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## **FEES AND PAYMENT POLICIES**

### **Neuropsychological Evaluations**

Dr. Papka charges \$175 per hour and applies this fee to all time associated with the evaluation, including the time the patient spends in the office for neuropsychological interview, behavioral and cognitive testing, and feedback visit, as well as the time that Dr. Papka devotes to the review of records, scoring of tests, report writing, and communicating with other healthcare professionals. The total amount of time spent on each case varies and can range between 8 and 20 hours or more, depending on the details of the evaluation. Given the large amount of time that is set aside for each evaluation, a 24-hour cancellation policy is enforced. Patients who do not provide 24 hour notice of a cancellation are responsible for payment for reserved time and any time spent on records review or consult with other physicians, family members, or others in order to prepare for the evaluation.

Except for Medicare, Dr. Papka is unable to accept payment from third party payers, such as insurance companies. Since many plans include benefits for neuropsychological services, the patient is encouraged to learn about the relevant policies of his/her health insurance plan that may make reimbursement possible.

***If the patient is insured by Medicare:*** Dr. Papka will bill Medicare for the services rendered. If Medicare accepts and agrees to payment, they will pay 80% of the claim and often forward the claim to the secondary carrier. In some cases, secondary insurance will cover the remaining 20%. It is the patient's responsibility to be knowledgeable of his/her benefits. The patient is responsible for payment not made by Medicare or other insurance. If there is a balance owed by the patient, this amount will be billed to the credit card listed on the New Patient Information Form or will be deducted from a \$262.43 deposit check. Any unused part of a deposit check will be reimbursed to the patient and/or additional amounts may be billed to the patient if appropriate.

***If the patient is not insured by Medicare:*** A deposit of \$700 by cash, check or credit card (listed on the New Patient Form) is needed to secure the appointment. Additional installments of \$700 will be collected at each additionally scheduled appointment. These amounts will be deducted from the total due at the end of the evaluation, or reimbursements will be made if appropriate. Account balances must be paid in full prior to the feedback visit and release of reports. It is the patient's responsibility to pay Dr. Papka directly and seek reimbursement from their insurance carrier independently if s/he wishes to do so. Once the evaluation is completed, Dr. Papka will provide an invoice to each patient containing all necessary information for claim submission (e.g, procedure codes, diagnosis codes, identifying information). If you plan to contact your insurance company before the evaluation to find out about possible reimbursement, the procedure codes used are 90801 and 96118.

I have read the above statements regarding fees and payment policies and agree to these terms.

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

The Atlantic Neuroscience Institute at Overlook Hospital  
99 Beauvoir Avenue, Box 271, Summit, NJ 07902  
Phone: (908) 322-5500 | Fax: (908) 322-7822 | [www.drnichellepapka.com](http://www.drnichellepapka.com)  
New Jersey License # SI 03813



**Michelle Papka, Ph.D.**  
Psychologist  
*Specializing in Neuropsychology and Psychotherapy*

### SELF-REPORT QUESTIONNAIRE

The information requested below will be used to help Dr. Papka understand the presenting problem and the medical, psychological, and social context in which these symptoms have occurred. Please complete the following questionnaire as accurately and honestly as possible. The information that you provide is confidential and will be used to aid in the evaluation, diagnosis, and treatment plan.

Name \_\_\_\_\_ Date \_\_\_\_\_

**Relevant History:**

What are you experiencing in your daily life that has caused you to seek a neuropsychological evaluation?

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When did these symptoms begin? \_\_\_\_\_ (approximate date)

Did the symptoms appear gradually or very suddenly? \_\_\_\_\_

Have the symptoms gotten worse, better, or stayed the same? \_\_\_\_\_

**Review of Symptoms:** Have you had any of the following **symptoms in the past month?** Provide details below if necessary:

	Yes	No	Describe
Loss of Consciousness			
Daytime Lethargy/sleepiness			
Disturbed Sleep			
Abnormal Vision			
Loss of Hearing			
Ringing in the Ears			
Dizziness/Vertigo			
Weakness in one part of the body			
Tremor/Shaking			
Involuntary movements			
Problems with Walking			
Imbalance			
Frequent Falling			
Frequent Headaches			
Weight Loss			
Weight Gain			
Depression			
Anxiety			
Hallucinations			
Delusions			
Incontinence			
Persistent pain			

**Reason for referral:**

Who referred you for this evaluation? \_\_\_\_\_

What information is being sought by this evaluation? \_\_\_\_\_

**Neuropsychiatric Work-up:**

Have you recently been evaluated by a neurologist or psychiatrist or had any related testing? \_\_\_\_\_

If so, please use the chart below to describe the purpose and status of these assessments. Please also list any pending evaluations.

<b>Type of Evaluation or Test</b>	<b>Physician or Facility</b>	<b>Date</b>	<b>Results</b>	<b>Did You Provide Copies of the Report? Yes /No Will These Be Mailed, Faxed or Brought to the Appointment?</b>
Neurological Evaluation				
Psychiatric Evaluation				
Neuropsychological Evaluation				
MRI				
CT				
EEG				
Blood work				
Other				

**Please mail copies of the above records with this packet**, or arrange to have copies of those records sent to Dr. Michelle Papka prior to the scheduled date of the neuropsychological evaluation. Records can be faxed to Dr. Papka’s attention at (908) 522-6147 or mailed to: Dr. Michelle Papka, The Atlantic Neuroscience Institute at Overlook Hospital, Box 271, 99 Beauvoir Avenue, Summit, New Jersey 07902.

**Medical History:**

Please list any past or current medical conditions, along with dates: \_\_\_\_\_

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Please list any past or current hospitalizations, along with dates: \_\_\_\_\_

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**Past Medical History:** Have you been **diagnosed** as having any of the following medical conditions?

Please provide details as necessary.

	Yes	No
Visual Loss		
Glaucoma		
Loss of Hearing		
Recurrent Vertigo		
High Blood Pressure		
High Cholesterol		
Heart disease (angina, heart arrhythmia)		
Lung disease (emphysema, COPD, asthma)		
Gastrointestinal disease		
Liver disease		
Chronic skin condition		
Arthritis		
Chronic sleep disorders		
Stroke or TIA		
Alzheimer's or other cognitive disorders		
Parkinson's or other movement disorders		
Chronic tremor		
Fainting or blackouts		
Seizures/epilepsy		
Seizures with high fever as child or baby		
Head trauma w/loss of consciousness		
Back Trouble		
Hematological disorders (sickle cell, hemophilia)		
Bleeding tendency		
Diabetes		
Thyroid condition		
Immunologic disorders (rheumatoid arthritis, lupus)		
Chronic allergies/hay fever		
Depression		
Psychiatric illness other than depression		
Kidney disease or other urological disorders		
Tuberculosis		
HIV or AIDS		
Encephalitis or Meningitis		
Polio		
Infections (Lyme..)		
Chronic gynecological disorders		
Cancer		

**Medications:**

Please list any current medications, along with daily dose:

Medication	Dose	Frequency	Prescribing Physician
<b>Vitamins and Herbal Supplements</b>			

Medication Allergies \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History:**

Does anyone in your family (i.e., blood relative) have a history of **neurological** or **psychiatric** illness?

Please use the chart below to list these relatives and their history.

Family Member/Relation	Illnesses	Age of Onset of Illness

Additional Comments:

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**Psychiatric History:**

Do you have a history of psychiatric or psychological disorders? \_\_\_\_\_

If so, please describe: \_\_\_\_\_

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Are you **currently** in treatment with a psychologist or therapist? \_\_\_\_\_

If so, for how long? \_\_\_\_\_ Is it helpful? \_\_\_\_\_

Name of Psychologist or Therapist: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Are you **currently** in treatment with a Psychiatrist? \_\_\_\_\_

If so, please provide name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please list any prescribed medication, including dose and duration of treatment: \_\_\_\_\_

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Please describe any **previous history** of psychological or psychiatric treatment:

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Have you ever been hospitalized for a psychiatric illness? \_\_\_\_\_

If so, please describe (and provide dates): \_\_\_\_\_

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**Social History:**

How many years of education did you complete? \_\_\_\_\_

What is the highest degree you obtained? \_\_\_\_\_

From what school did you receive your degree? \_\_\_\_\_

Are you retired? \_\_\_\_\_ If so, for how many years? \_\_\_\_\_

What is your current occupation? \_\_\_\_\_

For how long have you been at your current job? \_\_\_\_\_

Please describe your previous employment history: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your marital status? \_\_\_\_\_

If married, for how many years? \_\_\_\_\_

Are you divorced or widowed? \_\_\_\_\_ If so, for how many years? \_\_\_\_\_

Do you have any children? \_\_\_\_\_ If so, how many? \_\_\_\_\_

Do you live alone or with others? \_\_\_\_\_

Do you need help with your daily routine (e.g., grooming, dressing, driving, eating)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If so, do you have adequate help and support? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have a driver's license? \_\_\_\_\_ If so, which state? \_\_\_\_\_

How do you like to spend your leisure time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ If so, please describe your exercise routine:

\_\_\_\_\_

\_\_\_\_\_

**Alcohol/Drug Use:**

Do you smoke cigarettes? \_\_\_\_\_ If so, how many per day? \_\_\_\_\_

For how long have you been smoking? \_\_\_\_\_

If you do not smoke currently, have you ever smoked cigarettes? \_\_\_\_\_

If so, for how long did you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_

Do you smoke any other substances? \_\_\_\_\_ If so, please describe:

\_\_\_\_\_

\_\_\_\_\_

Do you, or have you ever, used any illicit drugs? \_\_\_\_\_ If so, please describe:

\_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ If so, please describe daily or weekly use:

Did the patient fill out the questionnaire? \_\_\_\_\_ Yes \_\_\_\_\_ No

If not, please explain and list the name of the person who completed this:

\_\_\_\_\_



**Michelle Papka, Ph.D.**

**Psychologist**

*Specializing in Neuropsychology and Psychotherapy*

Authorization Form

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## Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, Michelle Papka, Ph.D. to release:

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(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to:

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(Provide the name and address of person to whom the information is to be released.)

I am requesting my psychologist to release this information for the following reasons:

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(“at the request of the individual” is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until \_\_\_\_\_ (fill in expiration date) or until \_\_\_\_\_ (fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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New Jersey License # SI 03813

I am aware of my right to confidential communications under psychologist-patient privilege.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

If authorizing the use or disclosure of psychotherapy notes, I understand that such authorization cannot be required as a condition of treatment, payment, enrollment, or eligibility for benefits.

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Signature of Patient

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Date

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If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided



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**Acknowledgment of Notice**

I have reviewed and been offered written notice of psychologists' policies and practices with regard to the HIPAA Privacy Act. I understand and agree to the contents of this Notice. I also understand that I may contact Michelle Papka, Ph.D., should I have questions regarding my rights as a patient of this provider.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_



**Michelle Papka, Ph.D.**

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## **NEW JERSEY NOTICE FORM**

### **Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

“*PHI*” refers to information in your health record that could identify you.

“*Treatment, Payment and Health Care Operations*”

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

- *Payment* is when I may assist you in obtaining reimbursement for your healthcare. Examples of payment are if I disclose your PHI to your health insurer to help you obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

“*Use*” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

## **II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

## **III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse:** If I have reasonable cause to believe that a child has been subject to abuse, I must report this immediately to the New Jersey Division of Youth and Family Services.

**Adult and Domestic Abuse:** If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the county adult protective services provider.

- **Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

**Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

**Worker's Compensation:** If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

#### **IV. Patient's Rights and Psychologist's Duties**

##### Patient's Rights:

*Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

*Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

*Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

*Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

*Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologists' Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will notify you at the time of your next visit.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me, Michelle Papka, Ph.D. at (908) 322-5500.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Michelle Papka, Ph.D., 99 Beauvoir Avenue, Summit, NJ, 07902.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date**

This notice will go into effect on October 14, 2003.