



In order to provide each patient with the most accurate diagnosis, the doctor has recommended that you read the following recommendations prior to your first visit:

- **The diagnostic testing battery may take up to 2 hours due to the complexity of the multiple systems to be evaluated. The consultation with the doctor may take an additional hour, depending on how much time is required to explain your diagnosis. Please allow adequate time within your schedule.**
- **Women are asked to wear pants or shorts for testing.**
- **Please refrain from wearing any skin lotions, moisturizing creams, make-up, mascara, etc., on your face the day of testing.**
- **Please take your usual medications prior to the visit unless they are antihistamines, cough suppressants, strong pain medications, muscle relaxants or anti-dizziness medications.**

Frequently Asked Questions

How long will the testing take?

- Diagnostic testing for nervous system based disorders involves a complicated and time intensive process. You should expect to spend up to 2 hours of time during a Sensory-View test.

How often will I be expected to follow up with re-testing?

- The doctor would like to see re-testing done every 6-10 weeks. This re-testing provides the healthcare team with specific information to customize your plan of care and accurately follow your progress.

Will my insurance cover the treatment?

- Insurance is a contract between you and your insurance carrier. All of our testing is approved by Medicare and almost all insurance carriers. It is possible that some testing may be denied payment by your insurance carrier based on your contract. Our office will do our very best to pre-certify these tests with your carrier and keep you informed of your obligation prior to testing.



INSURANCE INFORMATION

APPT DATE _____

TIME _____

PATIENT NAME _____

DATE OF BIRTH _____

SS# _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PATIENT'S SYMPTOMS: _____

PRIMARY INSURANCE _____

ADDRESS _____ PHONE _____

INSURED NAME _____ DATE OF BIRTH _____

POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE _____

PHONE _____

INSURED NAME _____

DATE OF BIRTH _____ SS# _____



IRREVOCABLE ASSIGNMENTS AND FINANCIAL RESPONSIBILITY

I hereby authorize all Responsible Parties, to pay directly to NeuroSensory Center of Eastern Pennsylvania, Dr. Jeffrey Becker and Dr. Robert Bohlander, all benefits and amounts due for services rendered by the above doctors and staff.

I understand that if the above parties are not paid in full by proceeds of insurance benefits, then this assignment does not release my obligation and liability to the NeuroSensory center of Eastern Pennsylvania for payment of all services and items provided to me for the below referenced patient. In the event that no benefits are paid, then I agree to pay NeuroSensory Center of Eastern Pennsylvania and any and all of the above named practitioners for all charges in excess of the benefits paid. All payments will be made to NeuroSensory Center of Eastern Pennsylvania, at 250 Pierce Street Suite 317 Kingston, PA 18704.

Any check returned from the bank due to insufficient funds will result in an additional \$35 charge.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding, and I have signed this document freely and without inducement other than the rendition of services by the NeuroSensory Center of Eastern Pennsylvania.

Signature of Insured

Date

Signature of patient's Authorized Guardian

Witness



NeuroSensory Center of Eastern Pennsylvania

Suite 317 · 250 Pierce Street · Kingston, PA · 18704

T: 570.763.005 F: 570.763.0056

info@keystonensc.com www.keystonensc.com

PATIENT CANCELLATION / “NO SHOW” POLICY

We recognize the value of your time, and want your visit here to be a positive experience. We are continuing our efforts to eliminate any waiting times, whatsoever, for our patients. We schedule patients so that our entire professional team has sufficient time set aside to meet your individual medical needs. Please assist us in this effort by keeping your appointment and arriving on time, or by providing at least 24 hours advance notice if you must cancel your appointment. In order to encourage participation in this policy, a \$50 MISSED APPOINTMENT FEE will be billed to you if you do not keep your appointment, or if you fail to give 24- hour cancellation notice by calling the office. THIS FEE MUST BE PAID PRIOR TO SCHEDULING YOUR NEXT APPOINTMENT. We hope that this policy will ultimately benefit all patients by improving the quality of your diagnostic and treatment experience.

When you arrive for your appointment, please notify the receptionist and sign-in at the front desk. If you arrived on time for your appointment, notified the receptionist of your arrival, and then waited for more than 20 minutes past your scheduled appointment time, please let the receptionist know.

Sometimes the testing or treatment of certain patients takes longer than expected. Please know that your needs will receive the very same attention and care when you are seen by our staff.

Signature of Responsible Party

Date



NeuroSensory Center of Eastern Pennsylvania

Suite 317 250 Pierce Street, Kingston, PA 18704

T: 570.763.0054 F: 570.763.0056

info@keystonensc.com www.neurosensorycenters.com

Notice of Privacy Practices

To our patients This notice describes how health information about you (as the patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *NeuroSensory Center of Eastern Pennsylvania, ATTN: Sheila Becker RN, at 250 Pierce St. Suite 317 Kingston, Pa 18740*.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Sheila Becker RN at the above address*. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy has been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact *Sheila Becker RN at the above named office*. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact *Sheila Becker RN at 570-763-0054*.



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I authorize payment of my medical benefits to the undersigned Doctor for services rendered. I understand that NeuroSensory Center of Eastern Pennsylvania and its Doctors will make every effort to bill my insurance and obtain the necessary information needed to bill my insurance. I also understand that, if my insurance company fails to cover the services, I will be personally responsible for the benefits rendered. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to my privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct medical care services such as examinations, treatment, testing and other items pertinent to my medical care.
- I give my permission for my medical information to be discussed with the person(s) named here:

Patient Name: _____

Signed: _____ Date: _____



WAIVER

Dear Patient:

The Doctor may recommend a diagnostic procedure called the Computerized Dynamic Posturography (balance) Test. This test is very beneficial in both diagnostic and therapeutic decisions made by the Doctor.

Some insurance carriers have deemed this procedure medically unnecessary and deny payments. So, in our efforts to have this procedure recognized and covered by your insurance, we will file it with your insurance company at our regular fee of \$200.00. In the meantime, it is necessary that you pay a fee of \$125.00 at the time of service for the total patient responsibility for this procedure. However, if your insurance company pays for the procedure, you will be refunded your \$125 .00 prepayment minus any coinsurance or deductible charged by your insurance company.

I have read the above statements and understand that these procedures must be paid at the time of service.

Patient Signature

Date

Signature of patient's Authorized Guardian

Witness



Directions to the NeuroSensory Center of Eastern Pennsylvania

From the North (Scranton, Binghamton, Poconos)

Route 81 South to Exit 170B (Wilkes Barre/Bear Creek)
Proceed to Exit 3(Wilkes Barre/Plains)
Turn left at end of ramp onto River Street
At 5th traffic light take a right onto North Street
Go over bridge, now on Pierce Street
Proceed through 3 traffic lights
250 Pierce is on right, parking spots on either side of building

From the South (Hazleton, Harrisburg)

Route 81 North to Exit 170B (Wilkes Barre/Bear Creek)
Proceed to Exit 3(Wilkes Barre/Plains)
Turn left at end of ramp onto River Street
At 5th traffic light take a right onto North Street
Go over bridge, now on Pierce Street
Proceed through 3 traffic lights
250 Pierce is on right, parking spots on either side of building

From East/Southeast (Pocono, Lehigh Valley)

Route 476 (PA turnpike) to Exit 105 (Wilkes Barre/Bear Creek)
Turn left onto 115 North
115 North becomes Route 309 North
Proceed to Exit 3(Wilkes Barre/Plains)
Turn left at end of ramp onto River Street
At 5th traffic light take a right onto North Street
Go over bridge, now on Pierce Street
Proceed through 3 traffic lights
250 Pierce is on right, parking spots on either side of building

From the West (Williamsport)

Route 118 to Route 415
Turn right on Route 415 to Route 309 South
Route 309 to exit 3(Wilkes Barre/Bear Creek)
Turn left at end of ramp onto River Street
At 5th traffic light take a right onto North Street
Go over bridge, now on Pierce Street
Proceed through 3 traffic lights
250 Pierce is on right, parking spots on either side of building

From the Southwest (Bloomsburg, Berwick)

Route 80 East to Route 812
Route 81 North to Exit 170B (Wilkes Barre/Bear Creek)
Proceed to Exit 3(Wilkes Barre/Plains)
Turn left at end of ramp onto River Street
At 5th traffic light take a right onto North Street
Go over bridge, now on Pierce Street
Proceed through 3 traffic lights
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From the Northwest (Tunkhannock, Towanda, Sayre)

Route 6 South to Route 29 South
Route 29 South to Route 309 South
Route 309 South to Exit 3(Plains/Wilkes Barre)
Turn right at end of exit ramp onto River Street
At 5th traffic light turn right onto North Street.
At 5th traffic light take a right onto North Street
Go over bridge, now on Pierce Street
Proceed through 3 traffic lights
250 Pierce is on right, parking spots on either side of building