Montana Neuropsychological Associates

Mendy M. Bucy, MSW, LCSW
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Welcome to **Montana Neuropsychological Associates**. Our mission is to provide you with quality healthcare in a professional, efficient and caring manner. We have enclosed several documents to help you prepare for your upcoming appointments.

Appointment Information:
You will receive a confirmation call two weeks prior to your first appointment. If we don't reach you, a message will be left**. You must return our call within 48 hours or ALL upcoming appointments will be cancelled.** Appointments will automatically be cancelled if your number is disconnected or we cannot leave a message, as we cannot hold spots without confirmation. Please be aware – if you miss your appointment it may take several months to reschedule due to our high volume of patients. If you cannot keep your appointment, please notify our office **at least 48 hours** prior to your appointment so we have time to reschedule you as well as fill the spot you are unable to use.

Care for Minors:
Our practice is not able to contact all parties involved with a minor regarding appointment schedules. **The parent or guardian authorizing care for a minor will be the responsible party for the financial charges related to services and communicating to the other parent/parties involved.** If a divorce decree requires one parent to pay for treatment costs, it is the authorizing parents' responsibility to collect payment from that individual. Insurance typically will not pay for parents to meet separately with our providers; therefore, if you request this, it is your responsibility to pay for the additional visit at the time of appointment. If a patient is under guardianship, please bring a copy of the legal documents to the first appointment.

Enclosed Forms:

- Patient Information Form
- Financial Policy Form
- Initial Appointment Checklist
- Map to our Office

Thank you for choosing Montana Neuropsychological Associates.

Sincerely,

The Providers and Staff of Montana Neuropsychological Associates

Appointment Dates and Times

Initial Interview: _____

Testing: _____

Follow-up/Evaluation Results: _____

1622 South Ave. W., Missoula, MT 59801 | Phone 406.543.9700 | Fax 406.549.8109

Montana Neuropsychological Associates

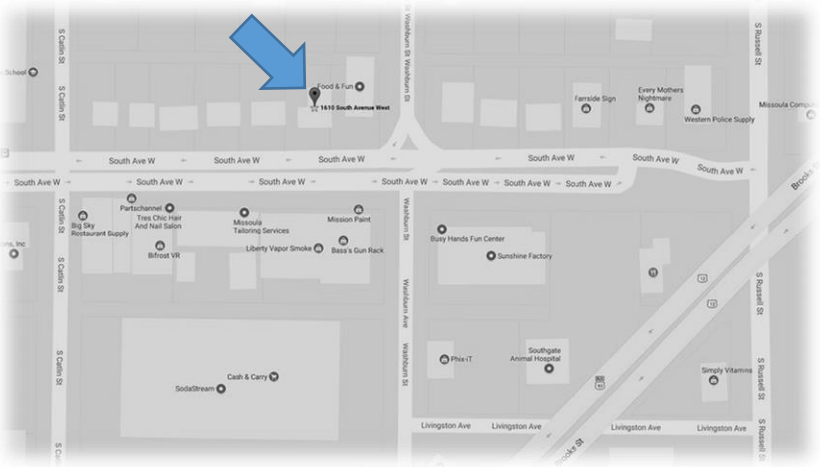
Initial Appointment Checklist

- ☐ Personal and Family History Questionnaire
- ☐ Patient Information Form and Financial Policy Form
- ☐ Records from other providers, previous evaluations, or school records (if applicable)
- ☐ List of current medications
- ☐ Any questionnaires sent with packet
- ☐ Insurance card(s) and ID
- ☐ Any required payments

Missoula Directions

Address: 1622 South Ave West, Missoula MT 59801

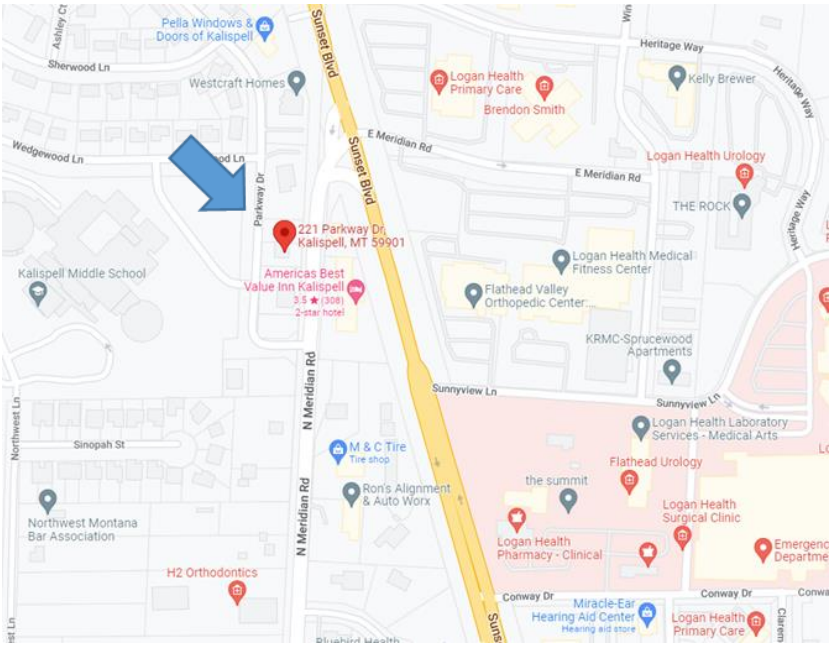
We are located approximately 1.5 blocks west of Malfunction Junction on the north side of South Avenue between Catlin and Washburn (we are the 2nd and 3rd buildings WEST of Washburn). Our offices are two green buildings with a small driveway between. Parking is behind the buildings (not directly on South Avenue).



Kalispell Directions

Address: 221 Parkway Dr, Kalispell MT 59901

We are located in the lower level of the Parkway Family Dental, across from Kalispell Middle School near Logan Health Hospital.



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Patient Information

NAME: LAST, FIRST, M.I.	BIRTHDATE	SEX	SSN#
ADDRESS	CITY	STATE	ZIP

PHONE	REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN
HAVE YOU SEEN ONE OF OUR PROIVIDERS? IF YES, WHICH PROVIDER?		

Employer Information (If patient is a child, please use parent's information)

self mom dad	EMPLOYER	ADDRESS

CITY	STATE	ZIP	WORK PHONE

Parent/Guardian Information - MUST BE COMPLETED IF different than above

NAME: LAST, FIRST, M.I.	BIRTHDATE	SEX	SSN#
ADDRESS	CITY	STATE	ZIP

WORK PHONE:	HOME PHONE	RELATIONSHIP TO PATIENT

Primary Insurance

POLICY HOLDER NAME	POLICY HOLDER BIRTHDATE	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE	POLICY#
GROUP#	POLICY HOLDER SSN#

ADDRESS OF INSURANCE COMPANY	CITY	STATE	ZIP

Secondary Insurance (If applicable)

POLICY HOLDER NAME	POLICY HOLDER BIRTHDATE	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE	POLICY#
GROUP#	POLICY HOLDER SSN#

ADDRESS OF INSURANCE COMPANY	CITY	STATE	ZIP

Emergency Contact

LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT	PHONE

MAILING ADDRESS	CITY	STATE	ZIP

I assign my benefits to MNA. I give my permission to MNA to disclose my personal data for treatment, account balance resolution, and other healthcare operations to appropriate agencies. I acknowledge and agree that I am responsible for payment of the total fee for services.

Patient/Guardian Signature: _____ Date: _____

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Financial Policy Form

It is our policy to collect a payment from all patients at time of service, based on type of insurance and/or coverage. We will determine an approximate cost for the evaluation and discuss this with you prior to the start of the evaluation. We make every effort to estimate the cost as accurately as possible; however, due to the clinical nature of our services there may be a balance due at the end of the evaluation. If a balance is due, payment is expected upon receipt of the final statement. If a refund is due, it will be paid to you as soon as all insurance payments have been received.

Please note – MNA is not contracted with all insurance companies and is not, at this time, able to complete single case agreements or negotiate payment arrangements with non-contracted insurances.

Private Insurance Patients:

1. Our billing office will obtain an estimated out-of-pocket cost for the evaluation.
2. If you have met your deductible, your co-payment is expected at each visit.
3. If you have not met your deductible, payment in-full for the estimated cost of the evaluation is due at the first appointment.

Self-Pay Patients (including Non-Insured, Third Party Coverage, Non-Contracted Insurance Companies, Motor Vehicle Accident evaluations):

1. Payment in-full for the estimated cost of the evaluation is due at the first appointment.
2. Patients will receive a statement from our office that can be submitted to your carrier/party responsible for payment.
3. Payment in full expected at each subsequent visit.

Medicaid, Medicare, VA Patients or Worker's Compensation Patients:

1. Co-pay, if applicable, is due at the time of each visit.

If you are unable to pay the estimated cost in full, we are more than happy to discuss a payment plan with you. Please contact our billing office at (406) 543-9700 prior to the first appointment in order to discuss payment options. If a payment arrangement is not approved, you will be required to pay the full out-of-pocket costs at the first appointment.

We accept cash, personal check, Visa, MasterCard, Cashier's Check, or Money Order.

** Ultimately, any account balance is your responsibility, regardless of anticipated insurance payment. Any balance remaining after insurance payment will be billed to the responsible party and is due upon receipt of the final bill **

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Financial Policy Continued...

Past Due Accounts:
Your account may be referred to an outside collection agency if the past due balance is more than 30 days old and you have not made payment arrangements with our office. If you default on a payment plan your account may be referred as well. **I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due.** This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees and any other fees so stated elsewhere. The authorized fee of **50%** and the additional costs and charges listed above represent the actual costs incurred by Montana Neuropsychological Associates to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement. Additionally, in the event your account is submitted to a collection agency, the fact that you receive treatment at our office may become a matter of public record.

Returned Check Fee:
There is a $25 fee for any checks returned by your bank.

By signing this policy you are agreeing to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____
Patient Name Patient DOB

_____ _____
Patient or Guardian Signature Date

_____ _____
Printed Name of Guardian Date

_____
Relationship to Patient