Brennan Behavior Group
433 Metairie Road – Suite 515
Metairie, LA 70005
504-833-6730 phone
504-833-6731 fax
www.brennanbehavior.com

LOUISIANA

Welcome to BBG! We are so excited you're here! Please complete the following paperwork.

Please specify what service you are requesting:

Autism Evaluation

Do you have a preference in which provider you will see?

No Preference

Date of Completion:

4/15/2025 1:02 PM

IF YOU HAVE MEDICAID

Unfortunately, we are not Medicaid providers for traditional therapy and testing services. **We DO accept Medicaid for ABA services.** For testing and therapy, you are welcome to schedule as a Self-Pay Client. If you are insured with United Healthcare or Aetna, please be sure to check your card to ensure that you have Commercial coverage. To schedule as a Self-Pay client, please fill out the insurance section in this paperwork as "Self-Pay".

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Patient Information Form

Patient's Name: LEDGER _____ Age: 11 ____ Social Security Number: _____

Parents' Name (if applicable): LISA PIERRE _____

Address: 31838 PEA RIDGE RD _____ City: ALBANY _____ State: LA ____ Zip: 70711 _____

Phone (H): _____ (C): 985-981-0742 _____ (W): _____

Email Address: LISAMBOTKIN@YAHOO.COM _____

Patient's Date of Birth: 11 ___/01 ____/2013 ____ Patient's Gender: M _____ Patient's Race: W _____

If a minor: School: ALBANY UPPER ELEMENTARY _____ Grade: 4 _____

If an adult: Marital Status: _____ Highest Level of Education: _____

Occupation: _____ Employer: _____

Referred by: DR. KRISTEN HOLLAS PhD _____

Emergency Contact: LANDRY PIERRE _____ Relationship: FATHER _____

Emergency Contact Phone: 985-969-7952 _____

GUARANTOR:

Name: LANDRY PIERRE _____ Guarantor Date of Birth: 5-30-86 _____

Address: 31838 PEA RIDGE RD _____ State: LA _____ Zip: 70711 _____

Employer: SPECIALITY WELDING & TURNAROUNDS _____ Employer Address: 40492 CANNON RD GONZALES LA 707 _____

Insurance Name: BCBS OF LA _____

Insurance Address: P.O.BOX 98029 BATON ROUGE LA 70898-9029 _____

Insurance Phone: 800-495-2583 _____

Policy Number: XUP202520760 _____ Group Number: 78L30ERC/0000 _____

Please upload a photo/copy of the front and back of your insurance cards below.

Primary Insurance: **Secondary Insurance:**

1 Attachment 0 Attachments

Office Policies

Billing Practices

While your insurance company may reimburse you for part of BBG's fees, it is your responsibility to pay your portion of the fees upfront unless other arrangements are made. Your portion of the fees will be collected at the beginning of each session. BBG accepts all major credit cards (subject to a 3% fee), checks, and cash. Checks should be made payable to "Brennan Behavior Group." Checks should **NOT** be made payable directly to the individual provider. If your check is returned for non-sufficient funds ("NSF") you will be charged a $35.00 NSF fee (as well as all other applicable bank charges).

Scheduling

When scheduling an evaluation, a clinical interview will be scheduled as well as a testing session and a feedback session. For therapy, sessions may be scheduled on a weekly, biweekly, or monthly basis. You are responsible for scheduling your recurring appointments.

Late Cancellation/No Show Policy

For all scheduled appointments, BBG's policy is that cancellations or rescheduling must occur no later than 48 hours in advance of the scheduled appointment. For example, if you need to cancel a Monday appointment, the appointment needs to be canceled by the previous Friday. If you reschedule or cancel with less than 48 hours' notice, you will be charged the self-pay cost of the visit. To avoid a NO SHOW/ CANCELLATION fee for missed appointments, cancellations must be made 48 hours or more in advance.

Additional Services

At times, it may be clinically beneficial or necessary for your therapist to provide services in addition to evaluation and/or therapy. These services may include, but are not limited to (i) phone consultations with adjunct mental health professionals, schools, attorneys, or physicians, (ii) writing reports or letters, or (iii) providing any other service authorized by you, including travel time, research, and/or any other services involving your care. Additional service fees for such services are set forth on the Assignment of Insurance Benefits and Patient Responsibility for Fees form. All accrued fees are to be paid in full prior to your next scheduled appointment unless prior arrangements have been made with BBG.

BBG Patient Portal

The BBG Patient Portal can be used to access multiple options, including reviewing invoices and unpaid balance, paying invoices online, reviewing upcoming appointments, and communicating with staff. Patients can access the patient portal by going to the website – www.brennanbehavior.com. Once on the home page, click "Patient Portal," then "Current Clients." When the "Current Clients" page opens, click on "Current Clients Access Portal Here." You will then be directed to the login page for the patient portal where you will enter the login and password you previously set up in response to the invite you received to the BBG Patient Portal. If you have any questions or difficulty accessing the Patient Portal and reviewing your invoices or making payments, please contact a member of BBG's staff.

Payment Policy

Payments are charged to your credit card on file on the date of service and the date insurance claims are processed. You can view your fees and charges, and pay your balance, at any time by accessing the BBG Patient Portal (see above). **It is your responsibility to review the BBG Patient Portal regularly to determine the status of fees incurred and amounts owed.** If you would like to pay for your services or your balance in a method other than the credit card on file, you must inform the office prior to your date of service or before insurance processes the claim. Balances for assessment and evaluation procedures are charged to the credit card on file the day before your scheduled feedback appointment. **For self-pay patients ONLY**: a $300 Clinical Interview balance will be charged to the credit card on file on the day of the Clinical Interview appointment. The remaining evaluation balance will be charged to the card on file at the time of the feedback appointment.

Minors Policy

It is BBG's policy to require a parent or guardian to be present and available throughout the entire evaluation for any child younger than six (6) years old. For children six (6) years old and older, a parent or guardian is not required to be present for the entirety of the evaluation. However, the parent/guardian assumes responsibility for the child during any time the child is not accompanied by BBG personnel. BBG personnel do not accompany children in the bathroom. By choosing not to accompany their child during the evaluation, the parent/guardian represents that the child can attend to all personal needs. The parent/guardian also understands that the child may be left unaccompanied in the BBG waiting room for brief breaks and transitions during the testing session at the discretion of the Brennan Behavior Group staff. Finally, parents/guardians assume responsibility for all children, regardless of age, for the lunch break (12 pm – 1 pm).

Evaluation Procedures

The testing portion of the evaluation is conducted by a specially trained technician who works under the direct supervision of your doctor. The technician will strive to make you and /or your child comfortable while administering the test(s) according to standard protocols. Your doctor will review the test results, interpret the test scores, prepare a written report, and meet with you to discuss the results. Results of testing are usually available 4-6 weeks after the assessment has

been completed. You will be contacted to schedule a "feedback" appointment once the test results are ready. NOTE: test results will NOT be forwarded to any agency or third party without signed, written consent and until the client or client's parents have had a chance to review the test results/report in full.

Records and Confidentiality

The information discussed in therapy and during the evaluation is treated as confidential. Except in a small number of situations, your clinician will not reveal any information about you/your child to another person without your explicit permission. Exceptions to this rule include, but are not limited to, (i) if your fees are paid by a third party such as an insurance company, certain details of your treatment (e.g., dates of treatment, diagnosis code) may be revealed in order to obtain reimbursement and (ii) where BBG has a legal responsibility to provide such information in response to a subpoena or court order. Records of your treatment will be kept for seven years after your final session.

Suicidality and Abuse

Brennan Behavior Group is legally required to disregard confidentiality in situations where there is a potential for suicide or homicide. For example, if you reveal information that indicates a clear and imminent danger of injury to yourself or others, the clinician will contact the appropriate authorities and/or family members. Similarly, the clinicians of Brennan Behavior Group are mandated reporters and, as such, are required by law to report any knowledge of abuse or neglect of a child, incompetent person or disabled person, including suspected abuse.

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms.

LP _____ 4/15/2025 1:15 PM _____

Signature of Client/Parent/Legal Guardian Date

Assignment of Insurance Benefits and Patient Responsibility for Fees

By signing this form, I authorize Brennan Behavior Group to submit claims for benefits for myself and/or my dependents for any and all services rendered without having to obtain my signature on each and every claim to be submitted and that I will be bound by this signature as though I personally signed each particular claim. I further agree and acknowledge that by signing this form, I am voluntarily authorizing the release of any information relating to all claims for benefits submitted for myself and/or my dependents.

For Assessments Only

Brennan Behavior Group administers a variety of evaluations and testing. There are many components involved in a psychological assessment, such as test administration, interpreting data, clinical decision making, and scoring data to produce an accurate clinical report to ensure proper treatment for our clients.

During evaluation and testing, BBG generally utilizes Current Procedural Terminology ("CPT") codes 90791, 96130, 96131, 96138 and 96139 (although sometimes other codes may be used as well). These codes are billed as the components of the assessment. **PRIOR TO SERVICES BEING RENDERED BY BBG, YOU SHOULD CONTACT YOUR INSURANCE COMPANY TO ENSURE THAT YOU AND/OR YOUR DEPENDENTS ARE COVERED FOR THESE CODES AND/OR THE SERVICES PROVIDED BY BBG.** While all services rendered by BBG are submitted to your insurance company for payment, you and/or your dependents may be subject to coinsurance and/or a deductible once claims have been processed by your insurance company depending on the specific insurance coverage maintained by you and/or your dependents. The estimated cost and/or amount of coinsurance and deductibles varies with each insurance plan and you should contact your insurer to obtain this information before services are provided by BBG. ****NOTE: Educational portions of testing are NOT covered by any insurance plan. You will be responsible for the full cost of all educational portions of testing administered by BBG****

LP (initial) I understand that I am financially responsible for ALL charges incurred for services rendered by BBG, including services not covered by insurance.

LP (initial) I understand that it is my responsibility as the patient/parent/guardian to determine if my insurance plan requires prior authorization for any services provided by BBG.

LP (initial) I understand that any insurance benefits, when received by and paid to Brennan Behavior Group, will be credited to my account.

LP (initial) I understand that if I do not appear for a scheduled appointment or fail to cancel or reschedule a scheduled appointment within 48 hours, a NO SHOW/CANCELLATION fee (equal to the self-pay cost of the visit) will be

automatically charged to my account and must be paid before my next scheduled appointment.

LP (initial) I understand that if I am late for an appointment, I will only be seen/treated for the time remaining in the appointment, but will be charged for the entire appointment time.

LP (initial) I understand that I must keep an active credit/debit card on file with Brennan Behavior Group and that my card will be charged according to the BBG Payment Policy.

LP (initial) I understand that if my (or my dependents') treatment ever involves the legal system, including but not limited to requests for depositions, expert testimony, consultation, responses to subpoenas, etc., I am responsible for all fees for such matters based on the Brennan Behavior Group Forensic Fee Schedule, which is specific to each individual provider and which will be provided to me at the time such services become necessary.

LP (initial) I understand that if my or my dependent's account is referred to collections, I will be responsible for all attorney's fees incurred by BBG as a result.

Additional Fees

By my initials below, I acknowledge that I have been made aware that the following fees are charges that are **NOT COVERED BY INSURANCE**. (NOTE: Initialing does not mean you are consenting to these options, just that you were made aware of the cost).

LP (initial) Telephone calls with provider lasting longer than 15 minutes ($60)

LP (initial) School Observations ($180 per hour; 2 hour minimum)

LP (initial) Meetings between provider and school personnel ($165 per hour; 2 hour minimum)

LP (initial) Letters on behalf of the patient ($108 per letter)

LP (initial) Report Rush (within two weeks of assessment) ($400)

LP 4/15/2025 1:18 PM

Signature of Client/Parent/Legal Guardian Date

Consent to Treatment and Recipient's Rights

I hereby attest that I have voluntarily entered into treatment (or give my consent for the minor or person under my legal guardianship to enter into treatment) at Brennan Behavior Group. I consent to have treatment provided by a licensed clinician or intern/psychology assistant in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that I or BBG may discontinue the therapy/clinical services at any time, but BBG encourages that such a decision be discussed with the treating clinician so as to help facilitate a more appropriate plan for discharge.

Involuntary Discharge from Treatment

A client may be terminated from BBG involuntarily if, (i) the client engages in physical violence, verbal abuse, is in possession of a weapon, or engages in any illegal act at the clinic, or (ii) the client refuses to comply with BBG rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified regarding the involuntary discharge in writing.

I consent to treatment for myself (or my minor child) and agree to abide by the above-stated policies and agreements with Brennan Behavior Group.

LP _____ 4/15/2025 1:18 PM _____

Signature of Client/Parent/Legal Guardian Date

Authorization for Electronic Communication

As a convenience to me, I hereby request that Brennan Behavior Group communicate with me regarding my (or my minor child's) treatment/services via electronic communications (including via the internet, e-mail and text message). I understand that this means that Brennan Behavior Group providers/professionals may transmit my protected health information and other confidential information, including but not limited to information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment, to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted.

As the electronic transmission of information cannot be guaranteed to be secure or error-free, and its confidentiality may be vulnerable to access by unauthorized third parties, I agree that Brennan Behavior Group and associated clinicians shall not have any responsibility or liability with respect to any error, omission, claim, or loss arising from or in connection with the electronic communication of information to me.

After being provided notice of the risks inherent in use of electronic communications, **I hereby expressly authorize Brennan Behavior Group to communicate with me electronically**, which will include the transmission of my protected health information electronically.

I understand that in the event I no longer wish to receive electronic communications from Brennan Behavior Group, I may revoke this authorization by providing written notice to Brennan Behavior Group at 433 Metairie, Rd. Suite 515, Metairie, LA 70005.

I agree that Brennan Behavior Group may communicate with me electronically unless and until I revoke this authorization by submitting notice in writing. This authorization does not, however, allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties electronically.

By my signature below, I agree that I have read and understand the information in this document and agree to abide by its terms. I hereby authorize the transmission of my protected health information and other privileged information electronically as described above.

LP _____ 4/15/2025 1:19 PM _____

Signature of Client/Parent/Legal Guardian Date

HIPAA Privacy Patient Authorization Agreement

I understand that as part of my healthcare, Brennan Behavior Group originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity and that I have the right to review Brennan Behavior Group's Notice of Privacy Practices prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes, and to the parties, designated by me.

LP _____ 4/15/2025 1:19 PM _____

Signature of Client/Parent/Legal Guardian Date

HIPAA Privacy Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a)) I understand that:

- I have the right to review Brennan Behavior Group's Notice of Information practices prior to signing this consent;
- Brennan Behavior Group reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that Brennan Behavior Group is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that Brennan Behavior Group has already acted in reliance thereon.

LP _____ 4/15/2025 1:19 PM

Signature of Client/Parent/Legal Guardian Date

Authorization for Credit Card Use

As a service to our clients, Brennan Behavior Group provides the option of paying for services with a credit card. Even if you do not intend to use a credit card for payment, BBG requires a credit card to be maintained on file in the event of a lack of payment by the client or the insurance company. In order to process charges to your credit card account, the following information is required.

Name on Card	LISA PIERRE
Billing address with zip code	31838 PEA RIDGE RD
Is this an HSA card?	____ YES ___X__ NO
Credit Card Type:	___ VISA ___X__ MASTERCARD ____ DISCOVER ____AMEX
Credit Card Number	5178059444187323
Expiration Date (mm/yy)	02/28
CVV Code (3 digits on back of card; 4 digits for AMEX)	971

By signing below, I understand that payment is due at the time of service, including expenses not covered by insurance, missed appointments, and co-payments. I also understand that I have the option to pay by cash, check, or credit card at the time of service. Finally, I understand that if I have an outstanding balance or a missed appointment, my credit card will be charged for such outstanding balance or missed appointment.

By my signature below, I authorize Brennan Behavior Group to use this credit card information as payment for services as stated above and in the Consent for Treatment agreement.

LP _____ 4/15/2025 1:21 PM

Signature of Client/Parent/Legal Guardian Date

Brennan Behavior Group
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Reason for Referral:

Please fill out the following demographic information:

Patient Name: LEDGER PIERRE Age: 11 Gender: M

Grade: 4

School (if applicable): ALBANY UPPER ELEMENTARY

Have you been seen in this office before? If so, when and who did you see?:

NO

Reason for Visit:

AUTISM EVALUATION

How long has this been a concern?:

6 YEARS

What interventions have you tried (i.e., medication, tutoring, counseling)?:

IEP LEARNING DELAY, PSYCH THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY

Current medications?:

N/A

Who referred you to our office?:

DR. KRISTEN HOLLAS PhD

Is there a custody arrangement that affects medical decision making?:

NO