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Licensed Psychologist
Board Certified in Neuropsychology

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ASSOCIATES IN NEUROPSYCHOLOGY
– est. 1995 –

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Personal Information Sheet – Adult Form

Please provide the following information
DATE:
NAME: **DATE OF BIRTH:** **AGE:** **SOCIAL SECURITY NUMBER:**
ADDRESS: **CITY:** **STATE:** **ZIP Code:**
CIRCLE THE TELEPHONE NUMBER THAT THE OFFICE CAN CALL FOR NOTIFICATION OF APPOINTMENTS: **PHONE:** Home Cell **Permission to text your appointment reminders:** Yes or No **EMAIL ADDRESS (FOR COMMUNICATION AND/OR VIDEO CONFERENCING):** **Permission to email neuropsychological test results to email address:** Yes or No
EMERGENCY NOTIFICATION **NAME:** **PHONE NUMBER:** **PERMISSION TO RELEASE IN CASE OF EMERGENCY, PLEASE CIRCLE:** YES NO
REFERRED BY:
PRIMARY CARE PHYSICIAN:

PLEASE DESCRIBE THE MAIN PROBLEM(S) THAT YOU ARE HAVING AT THIS TIME:

WHEN DID THE PROBLEM(S) BEGIN?

PLEASE CIRCLE ON THE SCALE BELOW AN ESTIMATE OF THE SEVERITY OF YOUR PROBLEMS:
MILD MODERATE SEVERE VERY SEVERE EXTREMELY SEVERE

ARE YOU RECEIVING SOCIAL SECURITY DISABILITY INSURANCE [SSDI]:	YES NO
ARE YOU RECEIVING SOCIAL SECURITY INSURANCE [SSI]:	YES NO
HAVE YOU APPLIED FOR SSDI AND BEEN TURNED DOWN:	YES NO

ARE YOUR PROBLEMS OR SYMPTOMS THE RESULT OF A CONCUSSION OR TRAUMATIC BRAIN INJURY?
DATE OF ACCIDENT OR CONCUSSION:
DESCRIBE THE ACCIDENT OR TRAUMA AND THE TREATMENT THAT YOU RECEIVED:

REGARDING THE ACCIDENT OR TRAUMA:			
	YES	NO	Additional information if necessary
DID YOU SEE A DOCTOR FOR TREATMENT?			
DID YOU LOSE CONSCIOUSNESS?			
DID YOU STRIKE YOUR HEAD?			
DID YOU FEEL DAZED, DIZZY, OR LIGHT-HEADED? [PLEASE CIRCLE]			
WERE YOU ADMITTED TO A HOSPITAL?			
IF MORE THAN ONE CONCUSSION OR HEAD INJURY, PLEASE SEE SECTION BELOW.			

HAVE YOU EVER HAD ANY INJURIES THAT MAY HAVE RESULTED IN CONCUSSION OR INJURY TO HEAD OR NECK?
DATE & CAUSE:
DATE & CAUSE:

IS THERE ANY LAWSUIT OR LITIGATION PENDING REGARDING THE HEAD INJURY OR TRAUMA?	YES NO
PLEASE DESCRIBE WHAT THE PENDING LAWSUIT OR LITIGATION IS ABOUT:	

CURRENT EVENTS AND SITUATIONS THAT ARE CREATING THE MOST STRESS:

WHAT ARE YOUR GOALS/REASONS FOR NEUROPSYCHOLOGICAL/PSYCHOLOGICAL SERVICES?

COGNITIVE SYMPTOMS	YES	NO
CHANGES IN MEMORY:		
PROBLEMS WITH SHORT-TERM/IMMEDIATE MEMORY		
PROBLEMS WITH REMOTE MEMORY/PAST MEMORY		
POOR PLANNING AND PROBLEM SOLVING		
PROBLEMS WITH WORD FINDING		
PROBLEMS WITH NAMING OBJECTS		
GETTING LOST IN FAMILIAR ENVIRONMENTS		
PERIODS OF DISORIENTATION OR CONFUSION		
DECREASED ATTENTION AND CONCENTRATION		
DIFFICULTY UNDERSTANDING WHAT YOU READ		
TROUBLE UNDERSTANDING WHAT IS SAID TO YOU		
TAKING LONGER TO DO THINGS		
DIFFICULTY FOLLOWING DIRECTIONS		
FLUCTUATIONS IN AROUSAL [STARING OFF BLANKLY FOR PERIODS OF TIME DURING THE DAY]		
PROBLEMS WITH DECISION-MAKING		
PROBLEMS WITH INDECISIVENESS		
PROCRASTINATION		
DIFFICULTY INITIATING AND/OR COMPLETING CHORES AT HOME OR WORK		
DIFFICULTY WITH ARITHMETIC (BALANCING CHECKBOOK)		
DIFFICULTY DOING YOUR JOB		
UNABLE TO WORK		
PROBLEMS WITH COGNITION AND THINKING THAT ARE NOT LISTED ABOVE:		

MOOD AND BEHAVIOR SYMPTOMS	YES	NO
DEPRESSED MOOD MOST OF THE DAY, NEARLY EVERY DAY		
LOSS OF INTEREST OR PLEASURE IN PREVIOUSLY ENJOYED ACTIVITIES		
SIGNIFICANT WEIGHT LOSS		
CHANGES IN SLEEP PATTERNS:		
SLEEP DISTURBANCE [FALLING ASLEEP/STAYING ASLEEP/NOT FEELING RESTED] (**PLEASE CIRCLE ALL THAT APPLY)**		
DURING SLEEP PHYSICAL MOVEMENT – HITTING, ARM MOVEMENTS, KICKING, RESTLESS LEGS **(PLEASE CIRCLE ALL THAT APPLY)**		
UNINTENTIONAL OR PURPOSELESS MOVEMENTS NOTICED BY OTHERS		
FATIGUE OR LOSS OF ENERGY		
FEELING WORTHLESS		
FEELINGS OF GUILT		
RECURRENT THOUGHTS OF DEATH		
EXCESSIVE ANXIETY OR WORRY		
RESTLESSNESS OR FEELING KEYED UP OR ON EDGE		
EASILY FATIGUED		
DIFFICULTY CONCENTRATING OR MIND GOING BLANK		
IRRITABILITY		
MUSCLE TENSION		
PANIC ATTACKS		
PHOBIC FEARS [IS SO PLEASE SPECIFY]		
AUDITORY HALLUCINATIONS		
VISUAL HALLUCINATIONS		
SUBSTANCE ABUSE – ALCOHOL		

SUBSTANCE ABUSE - DRUGS		
MOOD AND BEHAVIORAL SYMPTOMS THAT ARE NOT LISTED ABOVE:		

PHYSICAL SYMPTOMS	YES	NO
RECURRENT HEADACHES		
SEIZURES		
PROBLEMS/CHANGES WITH VISION		
PROBLEMS/CHANGES WITH HEARING		
PROBLEMS/CHANGES WITH TASTE		
PROBLEMS/CHANGES WITH SMELL		
DIZZINESS AND/OR LIGHT-HEADEDNESS (PLEASE CIRCLE WHICH APPLYS)		
NUMBNESS AND/OR TINGLING (PLEASE CIRCELE WHICH APPLYS)		
LOSS OF BALANCE		
CLUMSINESS (DROPPING THINGS, KNOCKING THINGS OVER, WEAK GRASP)		
RINGING IN YOUR EARS		
SENSITIVITY TO NOISE		
SENSITIVITY TO LIGHT		
FATIGUE/TIREDNESS/LACK OF ENERGY		
PAIN		
PROBLEMS BREATHING		
PHYSICAL SYMPTOMS THAT ARE NOT LISTED ABOVE:		

PREVIOUS DIAGNOSIS (PLEASE CHECK THOSE THAT APPLY)			
ATTENTION DEFICIT HYPERACTIVITY DISORDER [ADHD]		DRUG ABUSE	
ALCOHOL ABUSE		HEART DISEASE	
ALZHEIMER'S DISEASE		HYPERTENSION [HIGH BLOOD PRESSURE]	
AMNESIA		HYPERLIPIDEMIA [HIGH CHOLESTEROL]	
ANXIETY		LEARNING DISABILITY	
AUTISM/ASPERGER'S DISORDER		MIGRAINE HEADACHES	
BIPOLAR DISORDER		OBSESSIVE COMPULSIVE DISORDER [OCD]	
BRAIN TUMOR		PAIN DISORDER	
CANCER - TYPE		PARKINSON'S DISEASE	
CEREBRAL PALSY		PTSD	
CONCUSSION / HEAD INJURY / TBI		PSYCHOSIS	
COPD		SCHIZOPHRENIA	
DIABETES		SEIZURE DISORDER	
IF YES, MOST RECENT A1C LEVEL:		SLEEP APNEA	
DEMENTIA / NEUROCOGNITIVE DISORDER		STROKE (CVA)	
DEPRESSION		SUBSTANCE USE DISORDER	
DELIRIUM		THYROID DISORDER	
DEVELOPMENTAL DISABILITY		TOURETTE'S SYNDROME	
MEDICAL OR PSYCHOLOGICAL/PSYCHIATRIC CONDITIONS NOT LISTED ABOVE:			

MEDICATIONS	DOSAGE	CONDITION

PREVIOUS PSYCHIATRIC HOSPITALIZATION: [IF YES PLEASE PROVIDE REASON FOR TREATMENT AND DATES]	YES NO

PREVIOUS PSYCHOTHERAPY, PSYCHIATRIC TREATMENT, OR COUNSELING: [IF YES PLEASE PROVIDE A BRIEF DESCRIPTION]	YES NO
PAST:	
PRESENT:	

EDUCATIONAL AND WORK HISTORY
CURRENT OCCUPATION:
JOB DUTIES:
EMPLOYER:
PAST JOBS:
EDUCATION: HIGHEST DEGREE: GRADES IN SCHOOL:
PROBLEMS AT WORK OR SCHOOL [LEARNING DISABILITY, ADHD, CONFLICT WITH PEERS]:

MARRIAGE AND FAMILY

MARITAL STATUS: MARRIED SEPARATED PARTNER/COMPANION SINGLE WIDOWED DIVORCED

SPOUSE/PARTNER OCCUPATION: AGE: EDUCATION:

PREVIOUS MARRIAGES [DATES BEGAN AND ENDED]	
BEGAN	**ENDED**

CHILDREN

NAME	SEX	AGE	OCCUPATION	EDUCATION

TOTAL # PEOPLE LIVING IN HOME (INCLUDING PATIENT):	

SIBLINGS

NUMBER OF BROTHERS/STEP-BROTHERS: AGES:

MEDICAL OR PSYCHOLOGICAL CONDITIONS:

NUMBER OF SISTERS/STEP-SISTERS: AGES:

MEDICAL OR PSYCHOLOGICAL CONDITIONS:

FATHER

LIVING: YES NO AGE: EDUCATIONAL LEVEL:

OCCUPATION:

AGE AT TIME OF DEATH: CAUSE OF DEATH:

MOTHER

LIVING: YES NO AGE: EDUCATIONAL LEVEL:

OCCUPATION:

AGE AT TIME OF DEATH: CAUSE OF DEATH:

RELIGION AS A CHILD: AS AN ADULT:

CIRCLE ANY OF THE FOLLOWING THAT APPLIED DURING YOUR CHILDHOOD/ADOLESCENCE:	
HAPPY CHILDHOOD	STRONG RELIGIOUS CONVICTIONS
UNHAPPY CHILDHOOD	DRUG/ALCOHOL ABUSE
EMOTIONAL/BEHAVIORAL PROBLEMS	MEDICAL PROBLEMS
LEGAL TROUBLE	PHYSICAL ABUSE
SCHOOL PROBLEMS	SEXUAL ABUSE
FAMILY PROBLEMS	EMOTIONAL ABUSE
OTHER:	

PLEASE DESCRIBE FAMILY HISTORY, MEMBERS OF THE FAMILY THAT HAVE HAD A MENTAL DISORDER, E.G., ALCOHOL/DRUG ABUSE, ANXIETY, DEPRESSION, BIPOLAR DISORDER, SUICIDE ATTEMPT/COMPLETED, ETC.

FAMILY MEMBERS DIAGNOSED WITH DEMENTIA, NEUROCOGNITIVE DISORDER, NEUROLOGICAL DISEASE (ALZHEIMER'S DISEASE, MULTIPLE SCLEROSIS, PARKINSON'S DISEASE, ETC.)

Psychologist-Patient Agreement

Please review the Psychologist-Patient Agreement and the Kansas Notice Form on the Policies and Practices to Protect the Privacy of Your Health Information.

By signing below I am acknowledging that I have reviewed the Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information and the Psychologist-Patient services Agreement. I have read this policy statement and having been informed to my satisfaction, I give consent to treatment and/or evaluation by one of the psychologists in the group. I understand that by signing this form I am acknowledging that I understand the content of this form and agree to comply with all aspects of it.

Please Sign Name **Date**

Please Print Name **Date**

Patients or Authorized Persons Signature:

I authorize the release of any medical/neuro/psychological or other information necessary to process the insurance claim that is associated with the services that I have received. I also authorize payment of medical/neuro/psychological benefits to the provider of psychological services.

I also understand that I will be responsible for the payment of claims that are not covered by the insurance plan.

Please Sign Name **Date**

Please Print Name **Date**

Informed Consent for Neuropsychological Testing

Referral Source: You have been referred for a neuropsychological assessment (i.e., evaluation of your thinking abilities) by _____

Nature and Purpose of Assessment: The goal of neuropsychological assessment is to determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive functions. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your background and current medical symptoms we may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, listening to recorded tapes, viewing printed material, and manipulating objects.

Foreseeable Risks, Discomforts, and Benefits: For some individuals assessments can cause fatigue, frustration, and anxiousness.

Fees and Time Commitment: There is an hourly fee for this assessment.
Assessments may take several hours or more of face-to-face testing and several additional hours for scoring, interpretation, and report preparation. This evaluation time will vary and typically can range from two to approximately five hours of face-to-face assessment time. Most insurance companies provide benefits for neuropsychological testing. However, patients are responsible for all fees for the assessment.

Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; c) issuance of a subpoena from a court of law; d) audits or requests from your insurance company or a third party payor.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

_____
Patient Signature Date

_____
Parent/Guardian or Authorized Surrogate (if applicable) Date

_____ Witness
Signature

Authorization to Release Information

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 the psychologist (s), Associates in Neuropsychology and/or the administrative staff to release information about the psychological, cognitive, emotional, medical or social condition of

Name:_____

Date of Birth:_____

This information should only be released to (name and address of person to whom the information is to be released)
_____
_____
_____
_____

I am requesting the psychologist or their administrative to release this information for the following reasons: at the request of the individual or their representative

This authorization shall remain in effect until my association with the psychologist and administrative staff is completed.

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.

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 re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____

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.

CREDIT/DEBIT POLICY

Patient Name:_____

Date of Birth: _____

I understand it is the policy of Neal B. Deutch, Ph.D. and Associates in Neuropsychology "the office" to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of U.S. Law.

If after a claim has been submitted to my insurance carrier: 1) the claim is denied for any reason; or 2) there is patient liability (i.e., deductible, co-insurance, etc.): the office will send a statement notifying me of the balance due. If this amount is not paid within 30 days, then my credit or debit card will be charged for the entire balance owed for treatment or services provided to me or my dependent.

If insurance is used, I understand that my insurance company will also provide notification of these charges with an explanation of benefits.

I understand that in the event of my credit or debit card has been charged for the neuropsychological or psychological services and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a credit to my credit or debit card.

PLEASE CIRCLE ONE OF THE FOLLOWING:

Visa / Master Card / Bank Debit Card

Card account number: _____
Expiration Date: _____

Name of Card Holder:

I hereby authorize Neal B Deutch, Ph.D. and Associates in Neuropsychology and its designated employees to charge my credit/debit card as designated above, the patient responsibility and/or denied amount for neuropsychological or psychological services provided by the office. The charge will be based on the services rendered to me (or my dependent) and the usual and customary charges made by the office for said treatment and service. If payment is denied by my credit card company, I will pay the entire amount with 30 (thirty days).

_____ Date: _____
Cardholder's Signature