Building the Bridge Between Psychology and Medicine

Neuropsychology

PATIENT INFORMATION

Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Work Phone: _____

Date of Birth: _____ Sex: ☐ M ☐ F Social Security #: _____

Employer/School: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

BILLING INFORMATION

Name: _____ SSN# _____

Mailing Address: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other _____

Home Phone/Cell: _____ Work Phone: _____

INSURANCE INFORMATION

PRIMARY Insurance Co Name: _____

Subscriber's Name and Relationship to Patient: _____

Employer: _____ Phone: _____

Date of Birth: _____ ID#: _____ Group#: _____

SECONDARY Insurance Co Name: _____

Subscriber's Name and Relationship to Patient: _____

Employer: _____ Phone: _____

Date of Birth: _____ ID#: _____ Group#: _____

METHODS OF CONTACT

I hereby for consent ARCC Neuropsychology to contact the following individuals (patient included) regarding appointment scheduling, insurance related inquiries, or financial inquiries, until final payment is settled unless revoked by me in writing.

Name/Relationship	Phone Nr	Ok to leave message?	Ok to contact regarding: Scheduling	Insurance Info	Financial
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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ACKNOWLEDGEMENT & FINANCIAL AGREEMENT

By signing below, I acknowledge and consent to the following:

- I have consented to treatment provided by ARCC Neuropsychology and its employees. I understand that ARCC Neuropsychology serves as a training ground for mental health professionals and that I may be seen by a post-doctorate candidate who will provide care to me under the supervision of a licensed professional. I authorize the services deemed necessary or advisable by ARCC Neuropsychology to address my needs.
- If I have provided ARCC Neuropsychology with insurance billing information, I understand as a courtesy to me that they will bill my insurance carrier(s) directly.
- If I have provided ARCC Neuropsychology with insurance billing information, I authorize and request that my insurance plan(s) to pay directly to ARCC Neuropsychology the amount due for services rendered that are covered under the plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered until full payment is received.
- I agree to take full responsibility for the entire amount due for any and all services rendered. If ARCC Neuropsychology is contracted with my insurance carrier(s), I understand and agree that I am responsible for all co-pays, co-insurance, deductibles, and non-covered services as determined by the insurance plan(s).
- I understand that if a referral or prior authorization is required for services that I will be responsible for obtaining the appropriate referral or authorization for services. I further acknowledge that if a referral or prior authorization is not obtained prior to the date of service that I am responsible for the full amount of the services at the time of service.
- I acknowledge that authorization by my insurance plan(s) does not guarantee payment by the insurance carrier(s), and that if the carrier(s) denies payment for the services that I am responsible for payment of all charges.
- I agree that if I do not advise ARCC Neuropsychology about a change in my insurance coverage that I may be responsible for the full charges of services that occurred if payment is denied in part or full by my insurance carrier(s).
- I acknowledge that a cancellation/"no show" of less than 48 hours prior to the appointment time will incur a $75 charge – exceptions may be considered.

We are dedicated to seeing that every patient receives the services they need. To that end, we will make every effort to tailor your treatment to fill both your treatment needs and budgetary considerations.

I have read the policy described above and accept the conditions set forth.

_____

Print Patient Name

_____

Signature of Patient or Financially Responsible Party

_____

Date

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PATIENT HISTORY & HEALTH BACKGROUND

Patient Name: _____ Date of Birth: _____ Age: _____
Marital Status (or parent's marital status):_____Spouse Name: _____ Spouse's Age: ____
Immediate Family Member(s) and Their Age(s):_____
_____
_____

Referral Source
Name: _____
Address: _____
Phone: _____ Fax: _____

Primary Care Physician
Name: _____
Address: _____
Phone: _____ Fax: _____

Reason for referral: _____
_____

Presenting Problem: _____
_____
_____

Desired outcome of testing: _____
_____

What was the highest educational level reached by the patient? _____
What is/was the patient's occupation/career? _____
Date last worked? _____ Reason for ending job? _____

Please provide relevant social/family history. Please include significant life events.
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

TURN PAGE OVER

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Patient Name: _____ Date of Birth: _____ Date: _____

Please circle the appropriate answer to the following questions…

Do you use alcohol? Yes No How much? _____ How often? _____

Do you use drugs? Yes No How much? _____ How often? _____

Do you use tobacco? Yes No How much? _____ How often? _____

Medical History (Current conditions, inpatient hospitalizations, surgeries, etc.)

_____

_____

_____

_____

_____

Past Psychiatric Care (Inpatient treatment, evaluations, psychotherapy, medications)

Current and past psychiatrist: _____

Current and past therapist: _____

_____

_____

_____

Current Medications:

Name of Medication	Dosage	When taken	Date started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

_____

_____

Please circle the appropriate answer to the following questions…

Do you currently drive an automobile? Yes No

Have you been in a recent auto accident? Yes No

Have you designated another person as your medical power of attorney? Yes No

If yes, whom? _____ Relationship _____

FOR OFFICE USE ONLY:

Date reviewed with patient _____

Initials of reviewer _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, consent for ARCC Neuropsychology to contact **the following <u>healthcare professionals</u>** regarding my treatment, including information regarding behavioral health services, substance or alcohol abuse, HIV or AIDS, as deemed necessary. This includes forwarding the provider named below with a copy of my evaluation report(s).

PROVIDER NAME: _____

ADDRESS: _____

CITY _____STATE _____ ZIP _____

PHONE: _____ FAX: _____

PROVIDER NAME: _____

ADDRESS: _____

CITY _____STATE _____ ZIP _____

PHONE: _____ FAX: _____

I, _____, consent for ARCC Neuropsychology to contact **the following <u>individual(s)</u>** (eg. parent, child, spouse) regarding my treatment, including information regarding behavioral health services, as deemed necessary.

NAME: _____RELATIONSHIP: _____

ADDRESS: _____

CITY _____STATE _____ ZIP _____

PHONE: _____ EMAIL: _____

CONSENT TO SHARE: ☐ HEALTH INFORMATION & OFFICE NOTES ☐ FINANCIAL INFORMATION

☐ EVALUATION REPORT ☐ PSYCHOTHERAPY NOTES

INFORMATION RELATED TO: ☐ SUBSTANCE/ALCOHOL ABUSE ☐ HIV/AIDS

NAME: _____RELATIONSHIP: _____

ADDRESS: _____

CITY _____STATE _____ ZIP _____

PHONE: _____ EMAIL: _____

CONSENT TO SHARE: ☐ HEALTH INFORMATION & OFFICE NOTES ☐ FINANCIAL INFORMATION

☐ EVALUATION REPORT ☐ PSYCHOTHERAPY NOTES

INFORMATION RELATED TO: ☐ SUBSTANCE/ALCOHOL ABUSE ☐ HIV/AIDS

This consent will remain in effect from the date of signature for 365 days, unless specifically revoked in writing. If I do not sign this authorization ARCC Neuropsychology will not release my medical records.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE

OFFICE USE ONLY:

_____ _____

WITNESS DATE