Advanced Psychological Assessment, P.C.

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NEUROPSYCHOLOGY INTAKE FORM

This questionnaire was developed to obtain basic information about your child so that we can make the best use of our time together. You are not likely to remember every detail of your child's development, so it is not necessary to spend a lengthy period of time struggling with a particular point. Whatever information you may be able to provide will be helpful. If there are any specific questions that seem unclear, please mark them so that they can be clarified during our interview. Please review and sign the service/fee agreement at the end of this document. On the day of your appointment, make sure to bring your child's medical and school records, including prior evaluations that have been conducted.

PERSONAL INFORMATION

Name of Child:_____

Male☐ Female◉

Date of Birth:

Name of Mother/Legal Guardian:_____ Date of Birth:_____

Address:_____

Home Telephone:

Mobile Telephone:

Work Telephone:

Employment Status:_____

Name of Father/Legal Guardian: _____ Date of Birth:_____

Address: _____

Home Telephone: *Email*

Mobile Telephone:

Work Telephone:

Employment Status:_____

Referred by:_____ Telephone:

Family Physician:_____ Telephone:

Other Doctors:_____

Was the child adopted: No☐ Yes☐:
When _____Where_____

MARITAL STATUS

Are the parents
Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐

Do the parents live together: Yes ☐ No ☐

Number of years married, separated, divorced or widowed:_____

Are stepparents or other adults currently involved in the care of the child (please include names and relationship to child)?

1. _____
2. _____
3. _____

FAMILY COMPOSITION

Please indicate all other children and relatives living with the child including their names, sex, age, and relation to child:

Name	Sex	Age	Relationship	Yrs, of Educ.	Occupation/Grade

Please list immediate family members not living in the home (e.g., biological parent):

Name	Sex	Age	Relationship	Yrs. of Educ.	Occupation/Grade

IDENTIFICATION OF PROBLEM

Please describe in your own words the problem for which you are seeking this consultation including when the problem first arose:

What steps have already been taken to address your concerns?

How has the problem affected your family?

IDENTIFICATION OF PROBLEM (continued)

One problem may be related to or influenced by another family problem. Has your family experienced any of the following circumstances (Please indicate when):

Separation:	☐_____	Illness of Family Member:	☐_____
Divorce:	☐_____	Death of Family Member:	☐_____
Change of School:	☐_____	Loss/Change of Job:	☐_____
Addition to Family:	☐_____	Financial Stress:	☐_____
Legal Problems:	☐_____	Other Stress (specify):	_____

MEDICAL HISTORY:

Pregnancy with this child:

List complications during your pregnancy with the referred child (e.g., anemia, high blood pressure, toxemia, diabetes, infections, hospitalizations, etc.)?

No Complications No Complications

Were any medications/drugs used during pregnancy? If yes, please explain:

Length of pregnancy (in months):_____

Number of previous pregnancies:_____

Any Complications?_____

Birth History:

Length of labor (in hours):_____

Type of Delivery (check all that apply):

Normal Spontaneous Vaginal	☐
Induced	☐
C-Section	☐
Forceps	☐
Fetal distress	☐
Breech (feet first)	☐
Nuchal Cord (cord around neck)	☐
Twins	☐

Other (Please describe):_____

Newborn (check all that apply)*:*
Birth weight: _____
Blue at birth ☐
Required oxygen ☐
Had jaundice ☐
Required phototherapy ☐
Had Seizures ☐
Other:_____

Was medication used? Yes☐ No☐ If yes, reason:

Were their problems with:

Sucking ☐	Feeding ☐	Weight gain☐	Colic☐	Vomiting☐
Food refusal☐	Sleeping☐	Breathing ☐	Other:	

Has your child ever experienced:

Measles ☐	Mumps ☐	Seizures ☐	High fevers ☐	Meningitis ☐
Heart Disease ☐	AIDS ☐	Polio ☐	Whooping Cough ☐	Chickenpox ☐
Asthma ☐	Encephalitis ☐	Migraines ☐	Visual Defects☐	Hearing Defects ☐
Dizzy Spells ☐	Frequent Colds ☐	Scarlet Fever☐	Frequent Ear Infections ☐	Head Injuries☐
Head Aches ☐	Stomach Pain☐	Joint Pain ☐	Other:	

Food Allergies:_____

Drug Allergies: _____

Other Allergies: _____

Are there any medical problems currently affecting your child?_____

_____

Please list any medications, vitamins, or herbal remedies that your child takes or is prescribed:

Does your child require the use of corrective lenses: No

Does your child require the use of a hearing device? Yes ☐ No ☐

Has your child been treated by a mental health specialist (e.g., psychologist/psychiatrist)?
Name of Treatment Provider Age Date Started/Date Ended
1._____
2._____

Has your child ever been hospitalized due to medical concerns?

Description Age Length of Stay

1._____

2._____

Has your child ever been hospitalized due to mental health concerns?

Description Age Length of Stay

1._____

2._____

Please list any tests your child has completed:

Test	Age	Where	When	Physician	Result
Hearing					
Vision					
EEG					
CT Scan					
MRI					
Allergies					
Psychological					
Psychoeducational					
Other					

Note: Please provide copies of all test results and/or reports completed.

FAMILY MEDICAL HISTORY

Please list any serious physical, neurological, mental health issues or accidents that your family had to deal with:

Name Date Diagnosis Type of Treatment

1._____

2._____

3._____

Do any illnesses run in the family (e.g., diabetes, heart disease, etc.)? (Specify):

DEVELOPMENT

Please indicate your child's age when he/she achieved the following developmental milestones:

Milestone	Age
Sat alone	_____
Walked alone	_____
Toilet training	_____
First word	_____
Spoke 2 or 3 words together	_____

Do you have any concerns about your child's development in any of the following skills? (Please circle yes or no):

Gross Motor (walking, running, physical activities)	Yes	☐	No	☐
Fine Motor (use of pencil, manipulation of objects)	Yes	☐	No	☐
Speech & Language (comprehension, expression)	Yes	☐	No	☐
Cognitive Development (intelligence/ability to plan)	Yes	☐	No	☐
Social Development (play, social skills, peer interaction)	Yes	☐	No	☐
Independent Functioning (eating, dressing, toileting)	Yes	☐	No	☐

Other (please explain):_____

PHYSICAL CONCERNS

Please note & describe only symptoms that currently concern you regarding the child:

Weakness _____
Numbness _____
Clumsiness _____
Headache_____
Pain _____
Dizziness_____
Nausea_____
Visual Defects_____
Auditory Defects_____
Hear or see things that others do not_____
Problems or sensitivity to taste_____
Problems or sensitivity to smell _____
Problems or sensitivity to texture_____
Bladder/bowel control_____
Seizures_____
Fainting spells_____
Other (describe):_____

BEHAVIORAL CONCERNS

Please check only the behaviors that are currently of concern to you:

Temper Tantrums ☐	Sexual Difficulties ☐	Muscle Tics ☐	Vocal Tics ☐
Unusual Fears ☐	Destructiveness ☐	Aggressiveness ☐	Restlessness ☐
Excessive Sadness ☐	Cruelty to Animals ☐	Cruelty to Children ☐	Stubbornness ☐
Oppositionality ☐	Sleep Problems ☐	Overly Compliant ☐	Night Terrors ☐
Immature Behavior ☐	Suicidal Thoughts ☐	Self-Injurious Behavior ☐	Isolated ☐
Slowed Response ☐	Thumb sucking ☐	Breath Holding ☐	Fear of Separation ☐
High Activity Level ☐	Fire Setting ☐	Lying ☐	Stealing ☐
Defiance ☐	Self-Destructive Behavior ☐	Overeating ☐	Under-Eating ☐
Mood Swings ☐	Nightmares ☐	Drug Use ☐	Alcohol Use ☐
Smokes Cigarettes ☐	Truancy ☐	Easily Frustrated ☐	Withdrawn ☐

Other concerns (please describe):

CHILD MANAGEMENT

Who ordinarily manages/disciplines your child?_____

What have you found to be the most effective method of managing/disciplining your child (using rewards, taking away privileges, spanking, etc.)?

How does your child react to discipline?

EDUCATIONAL BACKGROUND

List all schools your child has attended beginning with the current school:

Name of School	School District	Grade(s) Attended	Grade Failures
1.			
2.			
3.			

Has your child received or been involved in any of the following?

	Grade/Age
Special Education Classes	_____
Inclusion Classes	_____
Tutoring	_____
Summer School	_____
Enrichment/Gifted Programs	_____
Language Immersion	_____
Resource Room	_____
Speech/Language Services	_____
Occupational Therapy	_____

Other (describe):

Has your child been classified by the school? Yes ☐ No☐

(If yes, please specify):_____

Are you satisfied with your child's present school program? Yes ☐ No☐

Comments:

Does your child:

Like school:	Yes ☐	No☐
Like teachers:	Yes ☐	No☐
Get along with peers:	Yes ☐	No☐

List any school problems that are of concern to you:

ADDITIONAL COMMENTS:
Describe what you see as your child's personal strengths (strong points):

Please provide any additional information that you feel is relevant to this referral:

Please attach a recent photograph of your child to this form:

Place picture here.

INFORMED CONSENT

Please read this section carefully:

WHAT IS A NEUROPSYCHOLOGICAL EVALUATION?

A neuropsychological evaluation is an assessment procedure involving interview and testing that is conducted by a licensed psychologist with a specialty in neuropsychology. The purpose of the exam is to identify the patient's brain-related areas of strength and weakness, provide diagnostic clarity and assist in the development of a plan of rehabilitation that will address the patient's problem areas.

The evaluation will involve the following:

1. Review of pertinent medical and school records;
2. Clarification of the referral question so that the neuropsychologist knows what kind of information and recommendations would be most helpful to all concerned;
3. Clinical interview with the patient and parents/legal guardians and other relevant individuals.
4. Administration of standardized tests designed to assess important areas of thinking, behavior, personality, and adaptive functioning.
5. Preparation of a detailed report documenting the patient's strengths, weaknesses, primary issues or challenges to adjustment and function and detailed recommendations to improve adjustment and function.
6. Copies of the report will be sent to the family, referring physician, school and other individuals for whom a signed release of information has been provided.
7. Review of the test findings and recommendations with the family.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

THIS NOTICE DESCRIBES HOW MEDICAL, MENTAL HEALTH AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Information about your treatment and care, including payment for care, is protected by two federal laws:

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")* and the Confidentiality Law**. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, record storage services, billing services);
3. For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal government);
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency ;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking a consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.)

*** 42 U.S.C. § 130d et. seq., 45 C.F.R. Parts 160 & 164**

**** 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2**

Your Rights

• Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

• You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.

• Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

• Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.

• If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.

• To make any of the above requests, you must fill out the appropriate form that will be provided by the program.

• You also have the right to receive a paper copy of this notice.

The Use of Your Information at the program

In order to provide you with the best care, the program will use your health and treatment information in the following ways:

• Communication among program staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.

• Communication with Business Associates such as clinical laboratories (blood work, urinalysis), food service (special dietary needs), agencies that provide on-site services (lectures, group therapy) long term record storage.

• Reporting data to the NYS OASAS Client Data System.

The Program's Duties

The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

Complaints and Reporting Violations

Patients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. The patient may complete a Privacy Complaint form (on reverse side of this form) and submit the form to the:

• ATC Administrator;

• Bureau of Addictions Treatment Centers, 1450 Western Avenue, Albany, NY 12203; or

• OASAS Privacy Official. , 1450 Western Avenue, Albany, NY 12203.

The complaint will be reviewed by an appropriate individual, based on the nature of the complaint. That individual will complete the Privacy Complaint Resolution form. Copies will be forwarded to OASAS Privacy Official, 1450 Western Avenue, Albany, NY 12203.

The patient may also register a complaint with the:

Office for Civil Rights

U.S. Department of Health and Human Services,

Jacob Javits Federal Building

26 Federal Plaza--Suite 3313

New York, New York, 10278

Voice Phone (212) 264-3313.

FAX (212) 264-3039.

TDD (212) 264-2355

OCR Hotlines-Voice: 1-800-368-1019

You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Breach Notification Addendum to Policies & Procedures

1. When the Practice becomes aware of or suspects a breach, as defined in Section 1 of the breach notification. Overview, the Practice will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. The Practice will keep a written record of that Risk Assessment.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

I will also obtain an authorization from you before using or disclosing:

· PHI in a way that is not described in this Notice.
· Psychotherapy notes
· PHI in a way that is considered a sale of PHI [We expect that few psychologists will be selling PHI because of ethical concerns.
· When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

POLICY

APPOINTMENTS & CANCELLATIONS

If you are unable to keep an appointment, please call to cancel as soon as possible. A complete evaluation requires between 8 and 12 hours so at least half a day is devoted to your appointment. You will be charged a fee of $500 for appointments that are not canceled at least 48 hours in advance, except in case of an emergency.

FEES

The cost of the evaluation is $5,000 due at the time of the first meeting . A typical evaluation requires approximately 12 hours total time, which includes the clinical interview, review of medical and school records, administration and scoring of tests, preparation of the report and providing feedback. Psychological treatment

The fee for psychological treatment is $150 per session. Cancellations must be done within 48hrs.

All records, including reports, test data and documents that are provided from other professionals on behalf of your child are kept in the strictest confidence in accordance with New York State and federal law and guidelines, except under the following conditions:

1. If you specifically waive your right to confidentiality
2. If your child poses a threat to him/herself or others;
3. If there is suspected abuse.
4. Please Review the attached HIPAA information.

This form was completed by:

_____ _____

Signature Print Name

_____ _____

Date Completed Relationship to Child