Arizona Neuropsychological Services, PLLC

Date: _____

PATIENT INFORMATION

NAME_____BIRTHDATE_____SEX: M F
ADDRESS_____CITY_____STATE_____ZIP_____
HOME PHONE_____CELL PHONE_____
E-MAIL_____SOCIAL SECURITY #_____
MARITAL STATUS_____PRIMARY LANGUAGE_____RELIGION_____

RACE (Circle One) HISPANIC BLACK/AFRICAN AMERICAN ASIAN WHITE EUROPEAN AMERICAN INDIAN OR ALASKA NATIVE NATIVE HAWAIIAN OR PACIFIC ISLANDER OTHER_____

EMPLOYMENT

EMPLOYER'S NAME_____OCCUPATION_____
EMPLOYER'S ADDRESS_____CITY_____STATE_____
EMPLOYER'S PHONE #_____ZIP CODE_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____
ADDRESS_____CITY_____STATE_____
HOME PHONE #_____WORK/CELL PHONE #_____ZIP CODE_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY_____POLICY#_____GROUP#_____
ADDRESS_____CITY_____STATE_____
ZIP CODE_____PHONE #_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____POLICY#_____GROUP#_____
ADDRESS_____CITY_____STATE_____
ZIP CODE_____PHONE #_____

IF PATIENT IS OTHER THAN THE INSURED, PLEASE COMPLETE THIS SECTION

INSURED'S NAME_____INSURED'S SOCIAL SECURITY #_____
RELATIONSHIP TO PATIENT_____INSURED'S DATE OF BIRTH_____
INSURED'S EMPLOYER_____INSURED'S EMPLOYER PHONE #_____
INSURED'S EMPLOYER ADDRESS_____

Arizona Neuropsychological Services, PLLC

It is the policy of Arizona Neuropsychological Services, PLLC to comply with the requirements of the national, state, and organization framework for health information privacy protection for the purpose of providing information to family, friends, and other third party entities.

In order to communicate your health status or permit any uses or disclosures of protected health information (PHI) to patient identified Family and Friends we will need your written permission.

_____ I agree to have Arizona Neuropsychological Services, PLLC communicate any uses and disclosures of PHI to my family and friends, providing they are involved with my care or payment of this visit.

Include:_____

Exception:_____
(specify the person's name who will NOT be permitted to have access to PHI)

_____ I do not agree to have Arizona Neuropsychological Services, PLLC communicate any uses and disclosures of PHI to my family and friends upon request.

Signature_____Date_____
(Patient signature)

Signature_____Date_____
(Guardian signature/relationship)

Witness signature_____Date_____

Arizona Neuropsychological Services, PLLC Notice of Privacy Practices (effective 10/1/2010)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to Dr. Morrone-Strupinsky about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **evaluation and/or treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our office, and you can always get a copy of it from Dr. Morrone-Strupinsky.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our office.

Arizona Neuropsychological Services, PLLC

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to guide our evaluations and treatment. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 480-855-4011.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to us. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative’s authority

_____

Signature of authorized representative of this office or practice

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative

Arizona Neuropsychological Services, PLLC
3115 South Price Road
Chandler, AZ 85248
Phone: 480-855-4011
Fax: 877-489-1513 or 480-855-2303

CONSENT FOR NEUROPSYCHOLOGICAL SERVICES

This consent form is to request the voluntary evaluation of _____ by Arizona Neuropsychological Services.

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

Nature and Purpose of Evaluation: The goal of the neuropsychological evaluation is to help you, your treating providers, family, and qualified third parties gain a better understanding of your relative strengths and weaknesses, and any changes from how you were functioning previously. Evaluation is helpful in identifying specific diagnostic considerations, and treatment recommendations. Neuropsychological tests are designed to evaluate brain-behavior relationships and help to determine if any changes have occurred in your attention, memory, language, problem solving, visual-spatial abilities, or other cognitive functions. A neuropsychological evaluation may point to changes in brain function and suggest possible methods and treatments for rehabilitation.

Evaluation Process: In addition to an interview in which I will be asking you questions about your background and current medical symptoms, I 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. True-false and self-report emotion and personality questionnaires may also be included. Supplementary records from hospitals, treating physicians, professional providers, schools, as well as interviews with designated family, care providers, and individuals who know you well may be included with your consent. The interview typically takes 30-45 minutes. Depending on the referral questions, testing can range from as little as 1.5 hours to as much as 3 hours. You will be given breaks as needed and requested. Once the tests are administered, the data analyzed, and relevant records reviewed, you will be provided with feedback to discuss the results and recommendations. Afterwards, the results will be incorporated into a written report that explains the test findings, diagnostic considerations, and recommendations.

Foreseeable Risks, Discomforts, and Benefits: For some individuals assessments can cause fatigue, frustration, and anxiousness about performance. Benefits associated with this assessment include gaining a better understanding of your current strengths and weaknesses, developing a plan to use your strengths to work with or accommodate your weaknesses, and identifying treatment that is specific to your needs.

Fees and Time Commitment: The hourly fee for this assessment is $150 per hour. A typical evaluation includes the time spent directly with you and others who are interviewed. It also includes additional hours for reviewing records, scoring and interpreting the tests, providing feedback, and report preparation. This comprehensive evaluation process is estimated to take 4-6 hours of time.

Payment and Assignment of Benefits: Though the fees are generally covered by insurance, patients are responsible for any and all fees for the evaluation not covered by insurance, including but not limited to deductibles, coinsurance and copays. By signing below, I am authorizing payment of benefits to Arizona Neuropsychological Services; payment of services is thereby directed to them. Arizona Neuropsychological Services may need to send information to the insurer to obtain payment for this evaluation.

Confidentiality: The records concerning this evaluation will be retained by Arizona Neuropsychological Services and will be kept confidential. No information will be released (other than to designated referring third parties where applicable) without prior written consent, except in the case of a medical emergency, to secure payment for treatment from health insurance plan or other third party payment system, or as permitted by law. Under the following circumstances, the law requires or permits that information be disclosed: 1. When there is reasonable suspicion of child abuse or neglect, or evidence of elder abuse. 2. When a person presents an imminent or potentially serious danger to self or others. 3. In the event of certain court orders, including subpoenas for judicial arbitration or mediation.

Release of Information: By signing the acknowledgement and consent form below, you agree to the release of both oral and written information to the referring party. In order to release information to individuals other than the referring party, you must sign a separate written consent form authorizing the release of the requested material to the designated party. By signing this form, I acknowledge that I, or my legal designee, have read and understood the above, that any questions I had were satisfactorily clarified and understood, and that I consent to the described services and limitations of confidentiality.

_____

Patient Signature/Date

_____

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

_____

Witness Signature/Date

Arizona Neuropsychological Services, PLLC

Please read and initial the following disclaimers to acknowledge your understanding

_____ I understand that this is a clinical evaluation. The purpose is to evaluate my cognition for medical reasons. It is not intended or sufficient to support litigation.

_____ I understand that if I have ongoing litigation and/or have legal representation related to a connected personal injury, we can't see you for a clinical evaluation. I confirm that I don't have such litigation or legal representation.

_____ I understand that it is important that I put forth my best effort. If I don't it will be detected in the data and the results will be invalid.

_____ I understand that completion of the report summary will take two weeks, so I should schedule any follow up appointments with my neurologist or other doctors to review these results at least two weeks after my appointment.

_____ I understand that anything I share with the doctor may be included in the report summary.

_____ I understand that the doctor will make no comments beyond what is in the report summary.

_____ I understand that Arizona Neuropsychological Services does not determine disability or work status, or complete forms, but will share my test results upon my request with the entities who make these decisions.

_____ I understand that Arizona Neuropsychological Services does not evaluate or comment on competency or my ability to manage my personal affairs (financial, medical, legal, driving, etc.).

Signature_____Date_____

Printed Name_____