Neuropsychology Intake Form

Patient/Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

Home Address: _____ City_____ ST ____Zip_____

Home Phone: _____ Name of person filling out this questionnaire: _____

Person who referred you: _____ May we thank this person? Y N

Parent Information

Father: _____ Age:_____

Address (if different):_____

Daytime Phone: _____ Cell Phone:_____

Education: _____Occupation: _____

E-Mail _____

Mother: _____ Age:_____

Address (if different):_____

Daytime Phone: _____Cell Phone: _____

Education: _____Occupation: _____

E-mail_____

Parents are: married separated divorced re-married deceased

Who has custody? _____

Sole Custody? Y N if yes, you must have legal documentation with you when you come.

Joint Custody? Y N We will need both parents' signatures before testing.

Referral Information

Problem Statement:_____

_____

_____

Describe your child's strengths: _____

_____

_____

Describe some of your child's weaknesses: _____

_____

_____

Do both parents agree about the nature and causes of the problem? _____

If not, please explain: _____

_____

_____

How do you discipline your child? _____

What is the result? _____

_____

_____

What do you hope to learn as a result of the evaluation? _____

_____

_____

Child is: biological adopted (at what age); foster (how long?)

Does the child prefer one parent over the other? Y N Which one? _____

Why? _____

_____

List Siblings and their ages: _____

_____

_____

Others living in home:_____

Is child in day care? Y N If so, how many hours/day? _____

Pregnancy and Birth History

Age of mother at delivery: _____ Age of father at delivery: _____

Number of prior pregnancies: _____

Number of prior miscarriages: _____Was a fertility specialist consulted? _____

Living circumstances during pregnancy: _____

_____

Known health problems of **mother** during pregnancy (circle all that apply)

Toxemia	Hypertension	Gestational Diabetes	Trauma
Fever	Allergies	Smoking	Alcohol Use
Drug Use	Antibiotics	Depression	Anxiety
Blood Incompatibility	Injury	Accidents	Emotional Abuse
Physical Abuse	Sexual Abuse	Spouses abuse:	Other:
Mental Illness	Sexually Trans. Disease	Other:	Other:

Please explain: _____

_____

List any medications, tobacco use, alcohol use, or drugs taken by mother during pregnancy: _____

_____

Delivery: Vaginal Cesarean If Cesarean, reason? _____

Full Term Premature

Weeks Gestation_____ Time spent in labor _____hours Birth Weight____ lbs. ____oz

Circle any birth complications that apply:

Feet first	Cord around next	Meconium staining	Lacking oxygen
Jaundice	Not breathing	Other:	Other:

Explain: _____

Apgar scores: _____ How old was baby at discharge from the hospital after birth? _____

Please explain any medical problems after discharge and interventions: _____

_____

Any problem in first few months? _____

Did you experience postpartum (after birth) depression? _____

Developmental History

Speech/Language:

Child's first language _____ Language spoken in the home _____

Age spoke first word_____ Age put 2-3 words together (short sentences)_____

Circle all that apply:

Speech delays	Stuttering	Hard to Understand	Late Drooling
Poor Sucking	Poor Chewing	Articulation Problems	Slow to learn alphabet
Slow to learn colors	Slow to learn counting	Other: _____	Other: _____

Please list any speech therapy services your child has received _____

_____

_____

Motor:

Age sat alone: _____ crawled: _____stood alone:_____ walked alone:_____

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball?) Y or N Explain:_____

Handedness: Right Left Ambidextrous (both)

Family history of left-handedness (list relatives)? _____

Please list any physical or occupational therapy services your child has received _____

_____

Toileting:

Age when toilet trained_____

Problems with: Bedwetting Urinating Soiling Explain: _____

_____

Any current problems? _____

_____

Medical History

Has vision been checked? **Y** or **N** Any problems: _____

Has hearing been checked? **Y** or **N** Any problems: _____

CT or MRI Date obtained? _____ Results: _____

EEG Date obtained? _____Results:_____

Other tests and results:_____

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____

Circle all that apply:

Failure-to-thrive	Febrile seizures	Epilepsy	Staring spells
Head injuries	Meningitis	Encephalitis	Asthma
Allergies	Diabetes	Loss of Consciousness	Abdominal pains
Vomiting	Headaches	Ear infections	Sleep difficulties
Sleep walking or talking	Eating difficulties	Eating disorder	Facial or other Tics
Repetitive movements	Impulsivity	Temper tantrums	Nail biting
Clumsiness	Head banging	Self-injurious behavior	
Physical injuries	Lead poisoning/toxic ingestion		
Other: _____	Other: _____	Other: _____	Other: _____

Please explain the age of occurrence, relevant information, and interventions of any conditions circled above:

_____

_____

_____

Current medications and reasons: _____

Child's Pediatrician and address: _____

Psychological and Treatment History

Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicide	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive Disorder	Personality Disorder
Other: _____	Other: _____	Other: _____	Other: _____

Please explain:

_____

_____

_____

Does anyone else in the family have a problem similar to your child's reason for referral?_____

_____

Child history

Has your child experienced (circle all that apply):

death of a loved one	separation from a loved one	emotional trauma	sexual abuse
family conflict	marital conflict	physical abuse	emotional abuse

Please explain_____

_____

_____

_____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	**Dates Seen**	**For What?**	**Describe Progress**

Please add any additional information you would like us to know: _____

Social Behavior

My child (circle all that apply)

Gets along with peers	Gets along with older children	Has a sense of humor	Gets along with adults
Keeps friends	Understands others' feelings	Understands social cues	Bullies others
Initiates play	Has problems with peer pressure	Is "bossy"	Is bullied by others
Is teased at school	Gets along with siblings	Initiates bad behavior	Has empathy for others

Please explain any pertinent issues regarding your child's social behavior: _____

_____

_____

_____

_____

Does your child make and maintain friendships? Y N Does your child have any close friendships? Y N

Please explain: _____

_____

_____

_____

_____

_____

Does your child have particular sensitivities (i.e., food, tags on clothing, etc.)? _____

_____

_____

_____

_____

Educational History

Current school and address: _____

Grade: _____ Placement: Gifted Regular Special Education (IEP)

Other_____

Any grades that were skipped? _____ repeated? _____

Teachers report problems in: _____

_____

Reading	Spelling	Arithmetic	Writing
Attention	Behavior	Social Adjustment	Hyperactivity
Impulsivity	Easily Distracted	Other: _____	Other: _____

Please describe the above noted problem(s) _____

_____

_____

Grade:	Academic problems? (Please describe)
_____	_____
_____	_____
_____	_____
_____	_____

Has your child been evaluated for special education? Y or N (If yes please provide a copy of the evaluation_____

_____

_____

Do teachers report problems that you do not notice? Y or N _____

_____

_____

_____

Do you see problems that teachers don't notice? Y or N _____

_____

_____

_____

Trilogy Integrated Psychological Services L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF DOCUMENTS

I, _____herewith acknowledge that I have received the following documents relating to my rights as a client of Trilogy Psychological Services.

Document Received/Reviewed	Parent/Guardian Initials	Parent/Guardian Initials
Policies and Statements of Informed Consent (PSIC)	_____	_____
HIPAA Notification (included within the PSIC)	_____	_____
Client Intake	_____	_____
Professional Fees/Financial Agreement	_____	_____

_____

Print Your Name Sign Your Name Date

_____

Print Your Name Sign Your Name Date

Trilogy
Integrated
Psychological
Services L.L.C.

Authorization for Release of Information

Client Information

Client Name: _____
Birth Date: _____

Authorization

I authorize Integrated Neuropsychological Services to **disclose, release, and/or receive information** to/from (**circle one**):
Name/Agency: _____
Relation to Client: _____
Address: _____
Telephone:

Information to be Released

_____
_____

Limits of Release: _____

Conditions of Release:

I understand that my signature authorizes the release of this information only between the above named persons or agency. This information may not be made available to others who request it secondarily and will not be re-released to any other person or agency. I understand that except to the extent that action has been taken on my authorization, I may withdraw this authorization at any time by written notification. I understand that this authorization shall remain in effect for ninety (90) days from the date on my signature below, unless I specify an earlier expiration date in this space:

_____ _____
Signature of Legal Guardian **Date**

_____ _____
Signature of Witness Date

Dr. John Mather, Dr. Nicole Huggins, Michael Schiebel, L.M.T.
4135 South Power Road, Suite 125. Mesa, AZ 85212
480-588-2204
trilogypsychological.com

Policies and Statement of Informed Consent

This document contains important information about Trilogy Psychological Services professional services and business policies. Please read it carefully and ask questions if you have any. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice which is attached to this Agreement explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about procedures at that time. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at anytime. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES AND FEES _____ Client's Initials (Or GUARDIAN if client is a minor)

Trilogy Psychological Services (TPS) offers neuropsychological assessment, psycho-educational and gifted intellect assessment, forensic evaluations, psycho-diagnostic sessions, psychotherapy and neurofeedback. Neuropsychological evaluations typically require between 6 and 10 hours from diagnostic interview through the feedback session. Psycho-educational and gifted intellect assessments typically take between 2 and 4 hours in total. The fee for neuropsychological, psycho-educational assessment, psychotherapy, and forensic evaluation is $150.00 per hour. Trilogy clinicians are available to attend school meetings for $100.00 per hour door to door. While report writing is included in the assessment fee, letter writing is an additional 150.00 per hour. Neurofeedback sessions are $100.00/hr.

COUNSELING / THERAPY SERVICES AND FEES _____ Client's Initials (Or GUARDIAN if client is a minor)
Therapy appointments are usually scheduled for 50 minutes. Longer appointments can be scheduled according to the client(s)' needs. Clients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time. The fee for individual and family therapy is $120.00 per hour. Group fees vary based on length and group size.

A 'no-show' is defined as failure to cancel a scheduled appointment 24 hours prior to the appointment or completely failing to show for a scheduled appointment. Our no-show fee is $150.00 per incident ($120.00 for a family/group session). Additionally, we require a non-refundable $300.00 retainer before we will schedule another appointment if a client cancelled two previous appointments. By signing this Agreement, you agree to comply with this policy.

CONTACTING TPS _____ Client's Initials (Or GUARDIAN if client is a minor)
Our office hours are typically 9 AM to 4 PM, Monday through Friday. The schedule will vary throughout the year. Individual provider availability may vary. We may be reached via phone at 480-456-0942 or via email at john@Trilogy.com. If no one answers the phone leave a message with detailed information and we will return your call by the end of the next business day. We will respond to emails by the end of the next business day. If you are difficult to reach, please include in your message times that you are most likely to be available. The clinical staff also finds it efficient to set phone appointments to ensure timely contact. If

you are unable to reach us and feel that you cannot wait you can call the **Maricopa Crisis Line @ 1-800-631-1314** or contact your family physician, call 911, or the nearest emergency room and ask for the psychologist or psychiatrist on call.

INTERNET CORRESPONDENCE(S)_____ Client's Initials (Or GUARDIAN if client is a minor)
It is often helpful to correspond through email over the internet. Trilogy uses secure email, however confidentiality cannot be guaranteed when communicating over the internet. If you would prefer that personal information not be exchanged over email, Trilogy staff will work with you to ensure that all communications will be conducted through direct interactions (phone or in person). By initialing the above you are permitting the exchange of confidential information over the internet and understand the limitations in confidentiality when doing so.

LIMITS ON CONFIDENTIALITY _____ Client's Initials (Or GUARDIAN if client is a minor)
The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by the Health Insurance Portability Accountability Act (HIPAA). There are other situations that require you provide written advance consent. Your signature on this agreement provides consent for those activities, as follows:

- We may find it helpful to consult other medical and mental health professionals about a case. During a consultation we do not reveal the identity of the patient. The other professionals are also legally bound to keep the patient information confidential. If you do not object, we will not tell you about these consultations unless we feel it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that we practice with other mental health providers and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member who has prior written authorization. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a patient threatens to harm himself\herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- Situations occur where we are permitted or required to disclose information without either your consent or Authorization:

    - If you are involved in a court proceeding and request is made for information concerning the professional services we provided you, such information is protected by the psychologist/therapist-patient privilege law. We cannot provide any information without you or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

    - If a government agency is requesting the information for health oversight

activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations may include:

- If we have reason to believe that a minor who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires us to file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.

- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires us to file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, we may be required to provide additional information.

- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim including themselves, and we believe that the patient has the intent and ability to carry out such threat, we must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS _____ Client's Initials (Or GUARDIAN if client is a minor)
The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

PATIENT RIGHTS _____ Client's Initials (Or GUARDIAN if client is a minor)
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS _____ Client's Initials (Or GUARDIAN if client is a minor)
Trilogy provides testing, assessments and counseling to minors, defined to be individuals under the age of 18. If a parent/legal guardian is bringing the child in for services, the **written consent of both parents** or legal guardians is required except as otherwise determined by law. Additional documentation of guardianship might need to be provided in certain circumstances, such as divorce, before treatment can begin.

BILLING AND PAYMENTS _____ Client's Initials (Or GUARDIAN if client is a minor)
Payment is due at the time of service. Please see our fee schedule, attached. Payment and/or copayment is due upfront. If you do not use insurance you will be responsible for pursuing any reimbursement from your insurance provider. Trilogy will provide you with a receipt for services for your records and to submit to the insurance company if necessary.

Upon scheduling your first appointment, you will be required to give your credit card information and agree to authorize Trilogy to charge that card for your sessions in the event that other payment has not been made at the time of service, or in the event of late cancellation or missed session that was not cancelled prior to 24 hr notice.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, all costs will be included in the claim and be the responsibility of the patient.

INSURANCE REIMBURSEMENT _____ Client's Initials (Or GUARDIAN if client is a minor)
Though all insurance companies claim to keep client information confidential, we have no control over what is done with it once it is in their hands. By signing this Agreement, you agree that we can provide any and all requested information to your carrier.

APPROVAL GIVEN

By signing this agreement you give us the permission to treat you or your child in accordance with the information stated in this document. This treatment includes but is not limited to neuropsychological assessment, psycho-educational/intellectual assessment, psychotherapy, group therapy and other treatments previously discussed and agreed upon with the patient.

Consent for Treatment

By signing below, you are stating that:

1) You have read and understood this 4-page (including this page) policy statement.

2) You have had your questions answered to your satisfaction.

I accept, understand, and agree to abide by the contents and terms of this agreement. Further, I consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time

_____

Patient's Name

_____ _____

Guardian's Name if patient is a minor Guardian's Name if patient is a minor

_____ _____

Patient or Guardian's Signature Date

_____ _____

Patient or Guardian's Signature Date