Neuropsychology Associates

10293 N. Meridian St, Ste 210 **Phone: 317-581-2292** **neuropsychologyassociates.net**
Indianapolis, IN 46290 **Fax: 317-581-2285** **npaindy@gmail.com**
Christopher Sullivan, PhD Ayca Byerley, PhD Alexandra Quast Surgener, PsyD
Crystal Ramos, PsyD Pamela Phillips, PsyD Andrea Moreau-O'Donnell, PsyD
Raymond Horn, PhD, ABPP Pam Freese, MSW, LCSW

Patient Registration Form

Please print

Referring Provider: _____

Patient Information

Name: _____Age:_____
Date of Birth_____ Sex_____ SocSec #_____

Parent Information

□Married □Separated □Divorced □Not Married □Other: _____
If applicable, who has physical custody? _____ Who has legal custody? _____

Parent 1 (Guarantor)

Name _____ Relationship_____
Address _____
City _____State_____ ZIP_____
Home Phone _____Cell Phone_____
OK to leave voicemail (please initial) Yes____ No____
Email Address_____ OK to email (please initial) Yes____ No _____
Employer _____ Marital Status_____
Level of Education _____

Parent 2

Name _____ Relationship_____
Address _____
City _____State_____ ZIP_____
Home Phone _____Cell Phone_____
OK to leave voicemail (please initial) Yes____ No____
Email Address_____ OK to email (please initial) Yes____ No _____
Employer _____ Marital Status_____
Level of Education _____

Is the patient currently involved in litigation? Yes ____ No ____
Is this a court-ordered evaluation? Yes ____ No ____
Is this a result of motor vehicle accident? Yes ____ No ____

Emergency Contact (in case parents cannot be reached)

Name _____ Relationship_____
Phone Number_____

Please turn over & complete the backside.

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company_____
Insured Name_____
Relationship to you: _____
Insurance ID #_____Policy/Group No._____
Insured Soc Sec # _____Insured Date of Birth:_____
Employer of Insured_____ Employer Phone_____
Insurance Phone # for provider_____

SECONDARY INSURANCE? Yes____ No____

Insurance Co_____
Insured name_____ Policy ID_____
Insured date of birth_____ Group #_____

INITIAL or SIGN & DATE PARAGRAPHS (as indicated):

_____I understand that appointments that are late cancels (within 24 hrs) or "no shows" are subject to a fee. Such charges are NOT covered by insurance.

_____If necessary to process an insurance claim, I authorize the release of any information acquired in the course of the examination or treatment to the company. I also assign payment of insurance benefits to the provider for services rendered.

_____I understand and agree that I am responsible for the balance of my account for any professional services rendered regardless of my insurance status. If collection proceedings are necessary, I agree to pay all fees associated with this process.

Signature of Insured or Guarantor_____ Date_____

I authorize the release of any information acquired in the course of the examination or treatment to the referral source responsible for payment of my account.

Signature of Insured or Guarantor_____ Date_____

I give my consent to have my/my child's photograph taken for the chart.

Signature of Insured or Guarantor_____ Date_____

Payment is due 30 days from date of invoice. Please call our office at 317 581-2292 with any questions.

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Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

This Notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and sign. If you wish to have a copy, please request from the front office.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions.

- ***'PHI'*** refers to information in your health record that could identify you.
- ***'Treatment, Payment and Health Care Operations'***
  - ***Treatment** occurs when one of our staff provides, coordinates, or manages your healthcare and other services related to your health care. An example is when our staff consults with another health care provider such as your family physician or another psychologist.
  - ***Payment** is when our office obtains reimbursement for your healthcare. Examples of payment include when our office discloses your PHI to your health insurer in order to obtain reimbursement for your health care to determine eligibility or coverage.
  - * **Health Care Operations** are activities that relate to the performance and operation of Neuropsychology Associates. Examples of health care operation include quality assessment and improvement activities, business-related matters such as audits, administrative services, case management and care coordination.
- ***'Uses'*** applies only to activities within our office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- ***'Disclosure'*** applies to activities outside of our office such as releasing, transferring or providing access to information about you to other parties.
- ***'Authorization'*** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

Neuropsychology Associates may use or disclose PHI for purposes of outside treatment, payment or health care operations when your appropriate authorization is obtained. In those instances when our office is asked for information for purposes outside treatment, payment, or health care operation, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations of releasing your PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Our office has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Neuropsychology Associates may use or disclose PHI without your consent or authorization in the following circumstances:

- * ***Child Abuse:*** If we believe that a child is a victim of abuse or neglect, we must report this belief to the appropriate authorities.
- * ***Adult and Domestic Abuse:***– If we believe or have reason to believe that an individual is an endangered adult, we must report this belief to the appropriate authorities.
- * ***Health Oversight Activities:***– If the Attorney General's Office (who oversees complaints brought against psychologists instead of the Indiana State Psychology Board) is conducting an investigation into our practice, then we are required to disclose PHI upon receipt of a subpoena.
- * ***Judicial and Administrative Proceedings:*** If you are involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, we will not release information without you or your legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party when the evaluation is court ordered. You will be informed in advance if this is the case.
- * ***Serious Threat to Health or Safety*:** If you communicate to our staff an actual threat of violence to cause injury or death against a reasonably identifiable victim(s) or if you make statements indicating an imminent danger that you will use physical violence or other means to cause serious personal injury or death to others, we may take the appropriate steps to prevent that harm from occurring. If we have reason to believe that you present an imminent, serious risk of physical harm

or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

* ***Worker's Compensation:*** We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient Rights:

Rights to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of PHI if you are paying out-of-pocket in full for your healthcare services. However, we are not required to agree to a restriction you request.

Right to Receive notification: You have the right to be notified if there is a breach of your PHI.

Right to Receive Confidential Communication by Alternative Means and at Alternative Locations: For example, you may not want a family member to know that you are being seen at our office. On request, we will send your billings to another address.

Right to Inspect and Copy: You have the right to inspect or obtain a copy of your PHI in the records used to make decisions about you for as long as the PHI is maintained in the record, and the record is maintained. We may deny your access to PHI under certain circumstances but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of releasing your PHI as long as the PHI is maintained in our office. We may deny your request. Upon request, we will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of the disclosure of your PHI. Upon request, we will discuss with you the details of the process.

Right to a Paper Copy: You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- **We must have a signed authorization before we can release any PHI** for any uses and disclosures not described in this Privacy Notice. Therefore, any calls requesting that we send information to someone will result in the patient or patient representative coming in to sign a release.
- We must have an authorization signed for the release of any therapy notes (if these are kept separately from the other records).

V. Questions and Complaints

- If you have questions about this notice, disagree with a decision we make about access to your records or have other concerns about your privacy rights, you may contact our office.
- If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to our address attention: Office Manager and please mark it confidential.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
- You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Charges and Changes to Privacy Policy

- This notice goes into effect September 1, 2013.
- Should you make a request for a copy of your record, it must be done in written format. We will charge you $0.15 per page and postage. This fee will be required prior to our sending your record to you.
- We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice at your next office visit.

I, the undersigned, acknowledge that I have read this Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information in the office of Neuropsychology Associates, and that I had the opportunity to ask for my own copy of this document to take with me.

Signed_____ Date_____

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Financial Responsibility Agreement for Testing

Neuropsychology Associates charges for services that are necessary to accurately assist with diagnosis and treatment. Evaluations are thorough and will not be inappropriately abbreviated in any way that would compromise the quality of the evaluation.

In recent years, many insurance carriers have drastically reduced authorizations or even eliminated coverage for neuropsychological evaluation of psychoeducational disorders, including Learning Disabilities and ADHD. Because of these limitations, providers are prohibited from billing insurance carriers for any portion of your or your child's evaluation that is **not medically necessary.**

Evaluations for the purposes listed below are not legally billable to most insurance carriers **for the reason that they are not judged to be medically necessary.**

*Learning Disabilities
*Primary purpose of assessing a learning disorder
*Vocational Testing
*Disability Evaluations
*Educational Planning
*Court Ordered Evaluations
*Fitness for Duty
*Capacity Evaluations

_____I understand that this portion of the testing will be billed to me separately.

Please initial to indicate that you have read the following statements.

_____I understand that the office does not take Medicaid or HIP programs.
_____Neuropsychology Associates will call insurance carriers to verify benefits based on the information given. It is ultimately the responsibility of the patient/legal guardian be aware of coverage to pay for any uncovered portion of the services rendered in the office.
_____I understand that my carrier will be billed for the covered charges that are allowed. I understand that I will be billed for the non-covered charges.
My credit card number is _____ exp. date_____ security code_____
The zip code that goes with the card _____. (please have card available at the appointment so staff can verify correct number)
_____I understand that Neuropsychology Associates will bill the insurance and actively work on getting payment of the services for 120 days. At that point I will allow a charge to my credit card for any remaining amount.

I have read the above statements and agree to this policy.

Sign _____Date_____

Left blank intentionally

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Symptom Checklist

Patient Name_____ Date of Birth_____

Presenting Concerns: _____

_____

Please answer the following questions that pertain to your child's health.

Please check if your child has experienced any of these within the last 3 months

	Loss of sense of smell		Any paralysis
	Change in sense of smell		Muscle weakness
	Smell of bad odors		Muscle twitching
	Loss of sense of taste		Muscle spasms
	Change in sense of taste		Trouble walking
	Bad tastes		Coordination problems
			Balance problems
	Blind in right eye		Tremors or shakiness
	Blind in left eye		Problem with dropping
	Blind in both eyes		
			Numbness
	Wear glasses		Tingling skin
	Wear contacts		"pins and needle" feeling
			Burning skin
	Blurred vision		Loss of feeling
	Double vision		Loss of telling hot from cold
	Loss of vision		Changes in skin
	Blank spots in vision		
	Flashing lights in vision		Pain
			Headaches
	Deaf in left ear		
	Deaf in right ear		Black-out spells
	Deaf in both ears		Seizures
	Wear a hearing aid		Fainting
	Loss of hearing		Periods of lost time
	Ringing in ears		
	Strange sounds in ears		

Medications:

***Flip Page to Fill out Other side

	Get lost often		**Do you experience:**
	Forget where you are		Sadness or depression
	Forget time and day		Stress, tension or anxiety
	Forget meetings		Anger or temper issues
	Have memory problems		Worry or guilt
			Change in your attitude
	Hear unusual sounds		Loss of interest
	See unusual things		
	Have strange feelings		**In the past have you had:**
			Childhood disease
	Can't think as quickly as you use to		Significant childhood injury
	Find it hard to think clearly		Head injury
	Easily distracted		Problems with nerves
	Can't concentrate		Running high fevers
	Have trouble with common sense		Serious infections
			Diabetes
	Do you have difficulty with:		Liver problems
	Using tools		Kidney problems
	Telling right from left		Problems with arteries
	Getting dressed		Stroke
	Remembering the correct word		Hypertension
	Understanding others		Heart problems
	Following conversations		Blood issues
	Speech		Cancer
	Reading		
	Writing		

Alcohol use ____ yes _____no. If yes, how much_____
Tobacco use ____ yes _____no. If yes, how much_____
Do you have any family history of medical or mental health issues?
If yes, please list:

Notes:

Developmental and Medical History Form

Please fill in the information or circle the appropriate answer.

Patient name_____ Date of Birth _____ Age_____
Child's School _____ Current Grade _____
Has the child repeated a grade? No Yes If yes, what grade _____
Is child in special education? No Yes If yes, what type _____
Is child adopted? No Yes If yes, at what age was the adoption _____
From where was the child adopted? _____

Please list all other family members living in the home:

Name	Age	School / Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY AND DELIVERY

Length of pregnancy: Full Term _____Weeks Length of delivery: _____ hours
Age of mother when child was born _____ Child's birth weight _____

Did any of the following conditions occur during pregnancy / delivery?	**NO**	**YES**
Bleeding		
Excessive weight gain (more than 30 lbs)		
Toxemia / preeclampsia		
Rh factor incompatibility		
Frequent nausea or vomiting		
Serious illness or injury		
Took prescription medications. If yes, list		
Took illegal drugs. If yes, list		
Used alcohol. If yes, _____ many drinks per week		
Smoked cigarettes. If yes, _____ cigarettes per day		
Was given medication to ease labor pain. If yes, medication used		
Was delivery induced?		
Were forceps used during delivery?		
Had a breech delivery		
Had a cesarean section delivery		
List any other problems		

Did any of the following conditions affect your child during delivery or within the first few days after birth?

	NO	**YES**
Injured during birth		
Cardiopulmonary distress during delivery		
Delivered with cord around neck		
Had trouble breathing following delivery		
Needed oxygen		
Was cyanotic, turned blue		
Was jaundiced, turned yellow		
Had an infection		
Had seizures		
Was given medications		
Born with a congenital defect		
Was in hospital more than 7 days		

INFANT HEALTH AND TEMPERAMENT

During the first 12 months, was your child….	NO	YES
Difficult to feed		
Difficult to get to sleep		
Colicky		
Difficult to put on a schedule		
Alert		
Cheerful		
Affectionate		
Sociable		
Easy to comfort		
Difficult to keep busy		
Overactive, in constant motion		
Very stubborn, challenging		

EARLY DEVELOPMENTAL MILESTONES

At what age did your child accomplish the following?

Sitting without help _____
Crawling _____
Walking alone (without assistance) _____
Using single words ("mama", "dada", "ball") _____
Putting two or more words together ("mama up") _____
Bowel Training, day and night _____
Bladder training, day and night _____

Did your child participate in early intervention services (e.g., First Steps)? Yes No

Did your child attend developmental preschool? Yes No

HEALTH HISTORY

Date of child's last physical exam: _____

At any time has your child had the following?

	Never	Past	Present
Asthma			
Allergies			
Diabetes, Arthritis, other chronic illnesses			
Epilepsy or Seizure Disorder			
Chicken Pox or other common childhood illnesses			
Heart or blood pressure problems			
High Fevers (over 103)			
Broken bones			
Severe cuts requiring stitches			
Head injury with / without loss of consciousness			
Lead poisoning/elevated lead levels			
Surgery			
Lengthy hospitalization			
Speech or language problems			
Chronic ear infections			
Hearing difficulties			
Eye or vision problems			
Fine motor/handwriting problems			
Gross motor difficulties, clumsiness			
Appetite problems overeating / under eating			
Sleep problems, falling asleep, staying asleep			
Soiling problems			
Wetting problems			
Other health difficulties - Please describe			

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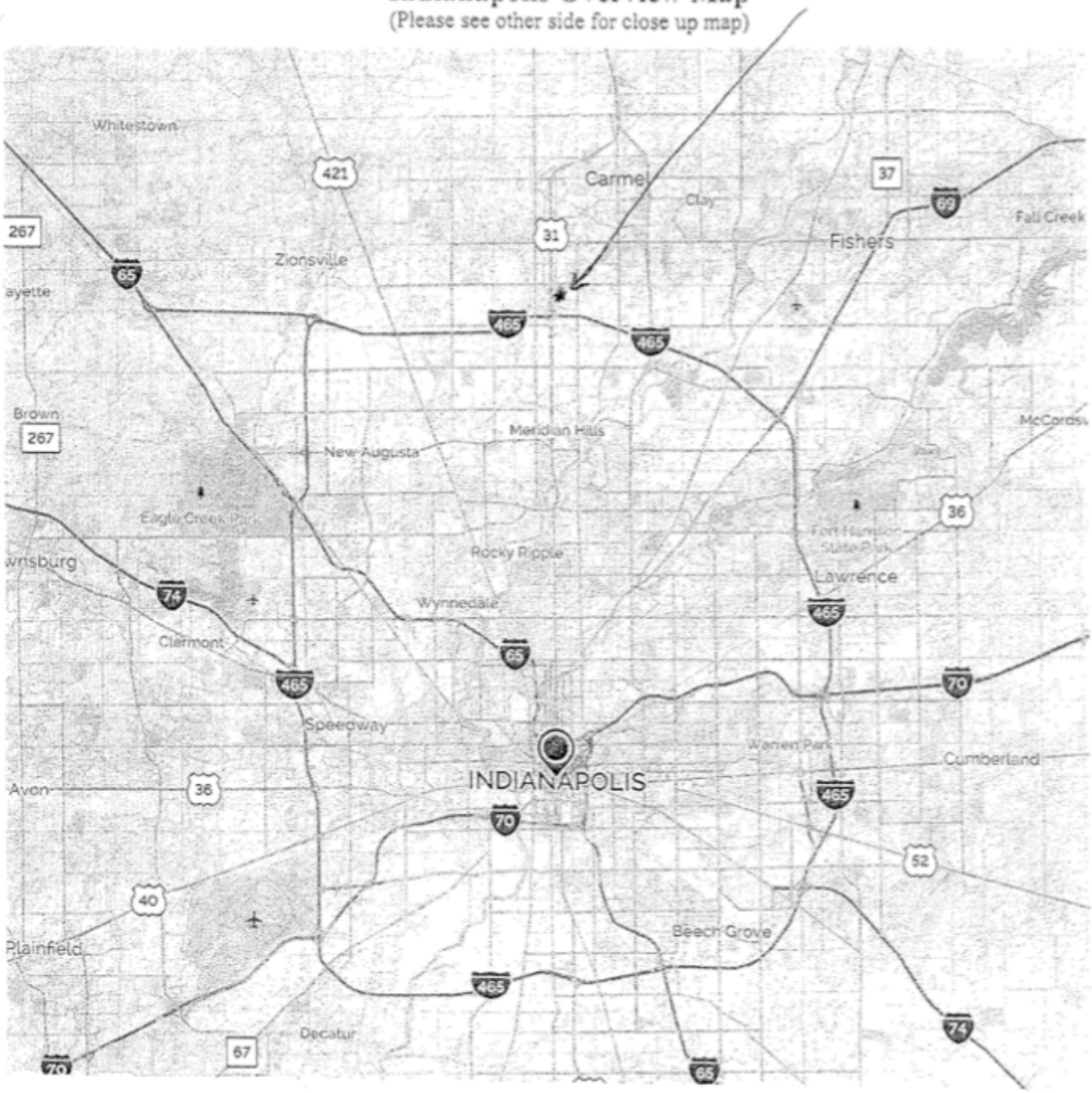
Indianapolis Overview Map

(Please see other side for close up map)



We are located on the southwest corner of 103rd and Pennsylvania Parkway. We are located in the three story red brick buildings with which columns. Our building number is 10293, Suite 210.

If you are coming in on 465, once you have exited 465 and are headed north you will need to get into the far right hand lane in order to exit off onto 106th street going east. Take a right at the roundabout and head south on Pennsylvania Parkway to 103rd.

If you are coming south on Meridian, you will need to exit off at the 106th street exit and go around the roundabout so you are headed east and proceed to Pennsylvania Parkway where you will head south by turning right and proceed to 103rd street.

If you are coming North of Meridian, follow the signs to 106th street exit and take a right so you are headed east on 106th street. Take a right at the roundabout and head south on Pennsylvania Parkway to 103rd.