Pathways Neuropsychology Associates | Health & Rehabilitation Services

Jay B. Gordon, Ph.D.
Licensed Psychologist #37590

PATIENT REGISTRATION
(Please complete all information)

Patient Name: (First)_____(Last)_____
Address:_____City/State_____Zip Code _____
Home Phone:_____ Work/Cell Phone:_____
E-Mail_____ **Date of Birth:**_____Male __Female __
Social Security #:_____**Marital Status:**_____
Full Name of Referring or Primary Care Physician:_____
Dr.'s Address & Phone Number_____
Emergency Contact Person:_____**Phone:**_____
Employer:_____**School:**_____

Insurance Information:
Insurance Name:_____
Phone:_____ **Address:**_____
ID#:_____**Group#**_____
Insured Full Name:_____Insured Date of Birth:_____
Insured Relationship to Patient:_____
Insured Employer:_____
Secondary Insurance: (Medicare patients only)
Insurance Name:_____Phone:_____
ID # : _____ Address: _____

RELEASE FOR PROFESSIONAL INFORMATION

I_____hereby authorize Pathways Neuropsychology Associates to_____ obtain/or_____release protected information pertaining to my treatment. This information should only be released to the following:
PCP/Physicians:_____

Attorney:_____

Other:_____
(If patient is a minor, parent or guardian are required to sign this release. (If minor is 14 years or older their signature is also required.)

SIGNATURE:_____Relationship:_____

APPOINTMENT CANCELLATION POLICY
We reserve the right to charge a reasonable and customary fee, $50.00 for missed appointments or services scheduled for you if you.....

1. Fail to call 24 hours in advance to cancel or reschedule.
2. Fail to attend the appointment without giving 24 hours notice.
3. Arrive too late for the doctor to see you at your scheduled time.

This is to confirm that I have been made aware of the above policy.

SIGNATURE: _____ Date:_____

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TODAY'S DATE: _____

NAME: _____
Last Name, First Name, M. Intl.

Age: _____ Date of Birth_____/_____/_____

CLIENT HISTORY

Please complete to the best of your knowledge. Try being as exact as possible in your answers.

MEDICAL/HEALTH INFORMATION

How were you referred to this office? (name of referring physician or organization)

_____

Reason for referral?_____

Has client ever had:

Head injury?..... No_____ Yes_____ Date_____
Other brain injury? ..... No_____ Yes_____ Date_____
Concussion?..... No_____ Yes_____ Date_____
Loss of consciousness or coma? ..... No_____ Yes_____ If so, how long?_____
Was client hospitalized?..... No_____ Yes_____ If so, how long?_____
Name and Address of Hospital?_____
_____
Details?_____

PAST MEDICAL AND PSYCHOLOGICAL TESTS

Has client ever had any of the following tests?

MRI..... No_____Yes_____Date_____
CAT (CT) Scan? ..... No_____Yes_____Date_____
EEG?..... No_____Yes_____Date_____
Psychological Tests/Evaluation..... No_____Yes_____Date_____
Details: _____

PAST MEDICAL AND PSYCHOLOGICAL HISTORY

Has client ever (prior to the current incident) had:

Heart disease?..... Yes_____ No_____
High blood pressure?..... Yes_____ No_____
Diabetes? ..... Yes_____ No_____
Seizures? ..... Yes_____ No_____
Thyroid Problems?..... Yes_____ No_____
Asthma?..... Yes_____ No_____
Learning disabilities? ..... Yes_____ No_____
Attention Deficit Disorder (ADD or ADHD)... Yes_____ No_____
Drug or alcohol abuse? ..... Yes_____ No_____
Psychological/Psychiatric problems? ..... Yes_____ No_____
Neurologic disease?..... Yes_____ No_____
Surgery? ..... Yes_____ No_____
Toxic exposures?..... Yes_____ No_____
Other medical disease?..... Yes_____ No_____

If so, when? _____
Details: _____

CURRENT HEALTH

Does client suffer from any of the following symptoms?

Headaches? ..... Yes_____ No_____
Backaches? ..... Yes_____ No_____
Sexual problems? ..... Yes_____ No_____
Menstrual difficulties? ..... Yes_____ No_____
Stomach problems? ..... Yes_____ No_____
Significant weight change?..... Yes_____ No_____ Gain or loss?
Numbness/weakness on either side of body. Yes_____ No_____
Pain?..... Yes_____ No_____
Location_____

Poor vision? ..... Yes_____ No_____
Sensitivity to light?..... Yes_____ No_____
Sensitivity to noise?..... Yes_____ No_____
Hearing impairment?..... Yes_____ No_____
Tinnitus (ringing in ears)?..... Yes_____ No_____
Decrease or increase in appetite?..... Yes_____ No_____
Change in taste?..... Yes_____ No_____
Change in smell?..... Yes_____ No_____
Loss of balance?..... Yes_____ No_____
Nausea?..... Yes_____ No_____
Dizziness?..... Yes_____ No_____
Sleep difficulty? ..... Yes_____ No_____
Nightmares?..... Yes_____ No_____
Changes in judgement?..... Yes_____ No_____
Poor concentration?..... Yes_____ No_____
Forgetfulness?..... Yes_____ No_____
Difficulty making decisions?..... Yes_____ No_____
Easily Distracted?..... Yes_____ No_____
Slowed thinking?..... Yes_____ No_____
Difficulty comprehending what others say?.. Yes_____ No_____
Academic difficulties in school?..... Yes_____ No_____
Difficulty managing daily activities?..... Yes_____ No_____
Language/Speech difficulty?..... Yes_____ No_____
Please explain_____
Changes in personality?..... Yes_____ No_____
Feelings of depression?..... Yes_____ No_____
Feelings of irritability?..... Yes_____ No_____
Poor frustration tolerance?..... Yes_____ No_____
Frequent negative thoughts?..... Yes_____ No_____
Frequent racing thoughts?..... Yes_____ No_____
Periods of hyperactivity?..... Yes_____ No_____ Anxiety/fear/panic?..... Yes_____ No_____
Feelings of unreality?..... Yes_____ No_____
Nervousness/shakiness?..... Yes_____ No_____
Decreased energy?..... Yes_____ No_____
Teeth grinding/clenching?..... Yes_____ No_____
Cold hands/feet?..... Yes_____ No_____
Sweating hands/feet?..... Yes_____ No_____
Heart pounding/racing?..... Yes_____ No_____
Thoughts of hurting yourself?..... Yes_____ No_____
Thoughts of hurting others?..... Yes_____ No_____
Behavioral difficulties in school?..... Yes_____ No_____
Problems with family or friends?..... Yes_____ No_____
Trouble participating in social settings?..... Yes_____ No_____
Trouble participating in sports?..... Yes_____ No_____
Fear of driving or riding in automobile?..... Yes_____ No_____

MEDICATIONS

Name(s)of Medications_____

_____

Dosage_____

FAMILY HISTORY

Mother: Age_____ Deceased? No_____Yes_____If so when?_____
Cause: _____

Father: Age_____ Deceased? No_____Yes_____If so when?_____
Cause: _____

Any brothers and/or sisters? ..... No_____Yes_____
Names and ages: _____

_____

Any children? ..... No_____Yes_____
Names and ages: _____

_____

Do any family members have any of the following: (If so, please specify who)

Diabetes?_____
Hypertension?_____
Thyroid Disease?_____
Epilepsy or seizure disorder?_____
Parkinson's Disease?_____
Multiple Sclerosis?_____
Intellectual Disability? _____
Psychiatric or psychological problems? _____
Learning disabilities?_____
Attention Deficit Disorder? _____
Alcoholism/Substance Abuse? _____
Alzheimer's Disease or Dementia?_____
Other Neurological problems? _____

LIVING ARRANGEMENTS

List everyone living in the home. (Name, age & relationship)

_____

_____

_____

ACADEMIC/VOCATIONAL HISTORY
Education: Name of school? _____

Please list subjects client has received the best grades in
(Please also list grade received)

_____

_____

Please list subjects client has received the poorest grades in
(Please also list grade received)

_____

_____

Work: Is client working now? Yes_____ No_____

Is client currently driving? Yes_____ No _____

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Consent for Purposes of Treatment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Pathways Neuropsychology Associates for the purpose of diagnosing or providing treatment to me and in obtaining payment for my health care bills. I understand that diagnosis or treatment of me by Pathways Neuropsychology Associates may be conditioned upon my consent and evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Pathways Neuropsychology Associates is not required to agree to a restriction that I request. However, if Pathways Neuropsychology Associates agrees to a restriction that I request, the restriction is binding on Pathways Neuropsychology Associates. I have the right to revoke this consent, in writing at any time, except to the extent that Pathways Neuropsychology Associates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Pathways Neuropsychology Associates, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Pathways Neuropsychology Associates Notice of Privacy Practices prior to signing this document and this has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the professional health care operations of Pathways Neuropsychology Associates. This Notice also describes my rights and Pathways Neuropsychology Associates duties with my protected health information.

Pathways Neuropsychology Associates reserves the right to change the Privacy Practices that are described. I may obtain a revised copy by calling the office, and I have the right to revoke this consent at any time.

Our office will make every attempt to collect payment from your insurance company. Please remember that payment of your bills is ultimately your responsibility. Your deductible and co-payment amounts are determined by the insurance coverage you and your employer selected. You are required to pay these deductibles and co-payments at the time of service. If you are in dispute of these amounts, it is your responsibility to address the problem with your insurance company. **All individual providers are billed under Tax ID #81-3236538. It is your responsibility to use this information to confirm that your provider is "in-network."** A "covered service" does not necessarily mean that it will be a paid service. As a result, you may be financially responsible for all or part of the services provided by our office.

I have read the information listed above and understand that I am financially responsible for all services not paid by my insurance company.

_____ _____

Patient Name Date

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2. Obtaining payment from third party payers (e.g. my insurance company);
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Patient Name: _____

Signature: _____

Relationship to Patient: _____

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MEMBERS' RIGHTS & RESPONSIBILITIES STATEMENT

Statement of Members' RIGHTS

- Members have the right to be treated with dignity and respect.
- Members have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Members have the right to easily access timely care in a timely fashion.
- Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care.
- Members have the right to information in a language they can understand.
- Members have the right to have a clear explanation of their condition and treatment options.
- Members have the right to information about Magellan, its practitioners, services and role in treatment process.
- Members have the right to information about clinical guidelines used in providing and managing their care.
- Members have the right to ask their provider about their work history and training.
- Members have the right to give input on the Members' Rights and Responsibilities policy.
- Members have the right to know about advocacy and community groups and prevention services.
- Members have the right to freely file a complaint or appeal and to learn how to do so.
- Members have the right to know of their rights and responsibilities in the treatment process.
- Members have the right to receive services that will not jeopardize their employment.
- Members have the right to list certain preferences in a provider.

- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to give providers information they need. This is so providers can deliver the best possible care.
- Members have the responsibility to ask questions about their care. This is to help them understand their care.
- Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Members have the responsibility to follow the agreed upon medication plan.
- Members have the responsibility to tell their provider and primary care physicians about medication changes, including medications given to them by others.
- Members have the responsibility to keep their appointments. Members should call their providers as soon as they know they need to cancel visits.
- Members have the responsibility to let their provider know when the treatment plan isn't working for them.
- Members have the responsibility to let their provider know about problems with paying fees.
- Members have the responsibility to report abuse and fraud.
- Members have the responsibility to openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____ _____

Patient Signature Date

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388 Lakehurst Road
Suite 2A
Toms River, NJ 08755
(732) 930-2242

1301 Route 72 West
Suite 250
Manahawkin, NJ 08050
(609) 597-5521

55 Schanck Road
Suite A-6
Freehold, NJ 07728
(732) 410-7110

www.pathwaysna.com www.addsolutionsnj.com

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name / Signature:

Patient Name:

Signature of Patient/Patient's Legal Representative:

Date: