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 _________
Stroke?	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:

Neurologic exam?	No _____	Yes _____	Date _________
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:

Diabetes?	Yes _____	No _____
Heart disease?	Yes _____	No _____
High blood pressure?	Yes _____	No _____
Seizures?	Yes _____	No _____
Thyroid problems?	Yes _____	No _____
Asthma?	Yes _____	No _____
Learning disabilities?	Yes _____	No _____
Drug or alcohol abuse?	Yes _____	No _____
Psychological/Psychiatric problems?	Yes _____	No _____
Neurologic disease?	Yes _____	No _____
Surgery?	Yes _____	No _____
Toxic exposures?	Yes _____	No _____
Parkinson's Disease?	Yes _____	No _____
Fibromyalgia?	Yes _____	No _____
Hydrocephalus?	Yes _____	No _____
Dementia?	Yes _____	No _____
Sleep apnea?	Yes _____	No _____
Multiple sclerosis?	Yes _____	No _____
Chronic obstructive pulmonary disease (COPD)?	Yes _____	No _____

Other medical disease?
If so, when? ____________________
Details? ____________________

ALCOHOL/TOBACCO USAGE

Please circle the one that applies to client:

Never or rarely drinks alcohol. Drinks socially only.

Drinks nearly every day. Has been treated for alcoholism.

I do not smoke. I smoke _____ packs of cigarettes per day.

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)

Psychiatric or psychological problems? ____________________
Learning disabilities? ____________________
Alcoholism/Substance Abuse? ____________________
Alzheimer's Disease or Dementia? ____________________
Other Neurological problems? ____________________

MARITAL HISTORY

Is client currently:

Married? ______ If so, how long? ______ Single______ Divorced______ Widowed______ Engaged_____

LIVING ARRANGEMENTS

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

____
____
____

SOCIAL HISTORY

Education: Highest grade or degree completed ____________________
If you attended college, which one? ____________________
Learning disabilities? ____________________

Work: Is client working now? _____ If not, when did you stop? ____________________
Present occupation? ____________________
How long at present work? ____________________

OTHER COMMENTS OR RELEVANT INFORMATION

PATIENT'S NAME: ______________________

DATE: ________________

PLEASE LIST YOUR CURRENT MEDICATIONS:

____

____

____

SYMPTOM CHECKLIST: Check all that apply

PHYSICAL		EMOTIONAL	
Headaches	___	Changes in personality	___
Backaches	___	Feelings of depression	___
Sexual Problems	___	Feelings of irritability	___
Significant weight change	___	Frequent racing thoughts	___
Numbness/weakness on either side of body	___	Anxiety/fear/panic	___
Heart pounding/racing	___	Feelings of unreality	___
Poor vision	___	Nervousness/shakiness	___
Sensitivity to light	___	Decreased energy	___
Sensitivity to noise	___	Fear of riding/driving in an automobile	___
Hearing impairment	___	Flashbacks	___
Tinnitus (ringing in the ears)	___	Thoughts of hurting yourself	___
Decrease/increase in appetite	___	Thoughts of hurting others	___
Change in taste	___		
Change in smell	___	**Emotional Total (0-12)** *for office use only:*	___
Loss of balance	___		
Poor coordination	___	**SLEEP**	
Nausea	___	Trouble falling asleep	___
Sweating hands/feet	___	Nightmares	___
Cold hands/feet	___	Sleeping more than usual	___
Teeth grinding/clenching	___	Sleeping less than usual	___
Pain	___		
Describe the location of the pain: ________			
Physical Total (0-21) *for office use only:*	___	**Sleep Total (0-4)** *office use only:*	___
COGNITIVE		**SOCIAL**	
Forgetfulness	___	Marital discord	___
Poor concentration	___	Problems with family/friends	___
Slowed thinking	___	Problems in work performance	___
Difficulty managing daily activities	___	Trouble participating in sports	___
Difficulty making decisions	___	Academic difficulties	___
Changes in judgement	___	Trouble participating in social settings	___
Difficulty understanding what others say	___		
Language/speech difficulty	___		
Explain language difficulty: ________			
Cognitive Total (0-8) *office use only:*	___	**Social Total (0-6)** *office use only:*	___

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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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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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: