



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: _____

"Dedicated to effective and compassionate care for individuals with neurological challenges."



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 _____

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(609) 597-5521

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

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



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.

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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: