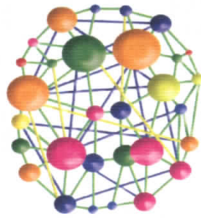
Robert Coben, Ph.D.
Clinical Neuropsychologist

Alexa Aragona, LMSW
Psychotherapist



Neurorehabilitation & Neuropsychological Services

Confidential Patient Information
(Please Print)

Date: ______________________________
Patient Full Name: ______________________________ SSN: ____________
If applicable, Guardian name: ______________________________

Date of Birth: ______________________ Gender: □Male □Female

Address: ______________________________ City/Zip: ______________
Home Phone:______________ Cellular/Pager:__________ Work Phone: __________
Occupation: ______________________ Place of Employment: ____________

May we contact you at work? □Yes □No May we leave a message for you at work? □Yes □No
May we leave a message for you at home? □Yes □No

Phone__________________ Email address ______________________________

If applicable, Spouse's/Significant other's name: __________ Place of Employment: __________

Referred by: ______________________ PCP: ______________________

Emergency Contact Name: ______________________ Relationship: ____________
Phone: ______________________

Were you involved in an accident? □Yes □No Motor Vehicle? □Yes □No Date: ____________
Are you represented by an attorney? □Yes □No Attorney Name______________________

With whom, if anyone, do you live? (Relationships & Names) ______________________

Have you ever been hospitalized? □Yes □No
If yes, please describe: ______________________________

Are you currently under a doctor's care for any medical problems? □Yes □No
If yes, please describe: ______________________________

Medication	Dosage (mg)	#/day	Medication	Dosage (mg)	#/day
1.			4.		
2.			5.		
3.			6.		

Reason for today's visit: ______________________________
____
____

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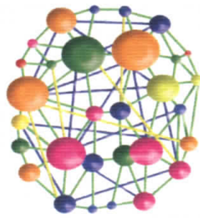

Neurorehabilitation & Neuropsychological Services

Please present insurance card(s) to be photocopied

Patient Insurance Information
(Please Print)

Primary Insurance Company: ____
Policy Holder's Full Name/Relationship to patient: ______________________________
Policy Holder's Date of Birth:________________________ Policy Holder's SSN:______________
Policy Holder's Employer: ____

Patient's Primary Care Physician ____

Secondary Insurance Company: ____
Policy Holder's Full Name/Relationship to patient: ______________________________
Policy Holder's Date of Birth:________________________ Policy Holder's SSN:______________
Policy Holder's Employer: ____

Responsible Party, if other than patient (who is responsible for payment of all costs incurred):
First Name________________________ Middle: ______________ Last: __________________
Address: _________________________City: ________________State: ____ Zip: __________
Home/Mobile Phone: ____ SSN: _____/___/_____
Employer: __________________________________ Work Phone: ______________________
Responsible party's relationship to patient: □Spouse □Child □Parent □Other__________________

I agree to authorize payment of insurance benefits to the service provider, authorize the release of any information necessary to process my claims, and accept payment responsibility for the portion of the bill that insurance does not pay within 60 days.

Signature: ____ Date: __________________

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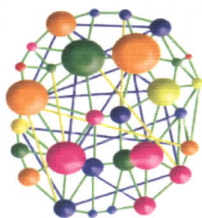

Neurorehabilitation & Neuropsychological Services

Patient Responsibility

I, ____ understand that I have contracted for psychological services with Neurorehabilitation and Neuropsychological Services, PC and that I alone am responsible for paying the full amount.

1). I understand that the practice provides insurance filing as a courtesy and convenience to me and/or will seek authorizations from my health care provider; however, these activities do not guarantee that my insurance will pay. I understand that at any time I am free to file my own insurance, in which case full payment of fees will be required at the time of service.

2). I understand that the business office will try to help me understand my insurance or managed care benefits and procedures, but that denial of my benefits by my insurer means that I am fully responsible for the billed amount. If your insurance company determined that a particular service is "not reasonable and necessary" or viewed as a non-covered service or diagnosis, your insurance will deny payment for that service.

3). I understand that I am responsible for meeting the requirements of my health insurer or managed care provider. In particular, I am responsible for:

A. Obtaining the initial referral to the provider, if needed.
B. Ensuring I have precertification of visits, if needed.
C. Knowing the limits regarding my deductible.
D. Keeping track of benefit limits. Keeping track of my benefits entails knowing any limits on my policy and ensuring that I do not exceed those limits (e.g. some insurers set a maximum of 20 mental health sessions per year). If I exceed my limits and my insurer refuses to pay, I will be responsible for the amount refused. Also, I understand that if I am seeing another psychologist or psychiatrist, those sessions may count against my mental health benefits. I also realize that while my managed care provider my authorize visits as appropriate for me, that does not mean that they will necessarily pay for those visits (e.g. some insurers will authorize 35 visits when they will only pay for 30 visits).

4). I also understand that if my policy changes or if I switch insurance companies, I should inform the office immediately. If the office does not have the proper information and cannot collect payment from the insurer, I am responsible for the amount the insurance company will not pay.

____ Patient, Guarantor

________________________________ Witness

____

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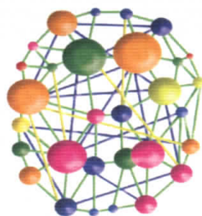

Neurorehabilitation & Neuropsychological Services

Consent for Psychological/Neuropsychological/Evaluation/Treatment

I understand that the purpose of this evaluation/treatment is to provide information about me for my physician or myself, either of which has requested the evaluation in order to assist in the diagnosis and treatment of me. The material from the interview(s) and psychological/neuropsychological testing will result in the generation of a report that will provide information related to diagnosis and treatment of me. If referred by my physician, the report generated by Neurorehabilitation and Neuropsychological Services, PC will be sent to my physician and Neurorehabilitation and Neuropsychological Services, PC will also discuss the results of the evaluation with them. If desired by me or my referring provider, Neurorehabilitation and Neuropsychological Services, PC will also discuss the results with me and any others which I so designate by signing a release of information allowing Neurorehabilitation and Neuropsychological Services, PC to do so. If this evaluation is being covered or partially covered by my insurance, Neurorehabilitation and Neuropsychological Services, PC may be required to provide the insurance company with a report as well.

I understand that questions asked by Neurorehabilitation and Neuropsychological Services, PC will touch on personal and private matters which may cause me emotional discomfort. I recognize that Neurorehabilitation and Neuropsychological Services, PC has no intention of causing any personal discomfort but is simply carrying out professional tasks associated with this evaluation. Even though some of the subjects under discussion may not appear at first glance to have a direct connection with the issue at hand, I will cooperate to the best of my ability. I understand that although I am expected to give honest and accurate answers, I am free to refuse to answer any question I choose or to terminate the evaluation whenever I wish.

Neurorehabilitation and Neuropsychological Services, PC is required to notify authorities if there is suspicion that a child is abused or if there is reason to believe that I may harm myself or others.

Treatment, psychological or neuropsychological, in any modality could cause emotional discomfort. This includes but is not limited to QEEG procedures, neurofeedback, and psychotherapy. I recognize that Neurorehabilitation and Neuropsychological Services, PC has no intention of causing any personal discomfort but is simply carrying out professional tasks associated with treatment.

In order for Neurorehabilitation and Neuropsychological Services, PC to ensure the evaluation and treatment procedures are efficacious, I give my consent for any non-identifying data from my record to be used for research purposes only. The terms of this consent have been reviewed, understood, and agreed to by me.

Client (or parent) Signature: ____________________________________ Date: ___________________

1035 Park Boulevard Suite 2B ◆ Massapequa Park, NY 11762 ◆ Tel: 516.799.8599 ◆ Fax: 516.799.4054 ◆ neuropsychlongisland.org

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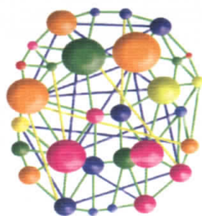

Neurorehabilitation & Neuropsychological Services

Clinic Policies

Services will be billed by the hour. In accordance with CMS standards of practice, billing for neuropsychological assessment will include time to (1) administer the test, (2) score tests, (3) interpret test/interview/records, (4) prepare the report, and (5) provide necessary feedback to the patient/family. For non-forensic cases, this will typically add 2-4 hours to the actual testing time. Forensic/medicolegal cases typically require more time and may include record review and consultation(s) with attorney(s), etc. You are required to pay all co-pays and coinsurance amounts. Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for any balance not covered by your insurance policy. As a courtesy, we will bill your insurance for you. We will make every effort to ensure that claims are complete and accurate when submitted; however, follow up on your insurance claims is your responsibility. *If your insurance does not reimburse us within 60 days, you will become responsible for the balance; you will be refunded any amount subsequently received by your insurance company.*

For Medicare patients: We are a participating provider and, therefore, accept assignment. We will also bill any secondary insurance policies; however, you will be responsible for any balance remaining after all policies have been billed.

For patients with a pending Workman's Compensation claim, personal injury claim, or other litigation: We will bill all relevant insurance carriers. In the event reimbursement is not received within 60 days, you will be responsible for any remaining balance. Please note, contingency fee arrangements are prohibited by our professional ethical standards.

We are pleased you have chosen to come to our clinic. Please do not hesitate to request a clarification of any clinic policies or ask any other questions regarding your service. Neurorehabilitation and Neuropsychological Services, PC office staff is happy to respond to any concerns.

Guarantee of Payment and Assignment of Insurance Benefits

The undersigned guarantor (hereinafter "the Undersigned") and/or patient (hereinafter "the Patient") promises to pay to Neurorehabilitation and Neuropsychological Services, PC (hereinafter "Provider") all charged incurred for services rendered to the Patient. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) as a courtesy to the Undersigned, and the Undersigned and/or the Patient authorize Provider to release any and all medical information necessary to complete the insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered b y Provider in the event insurance does not pay for these services. It is acknowledges that completing a following-up of any insurance claims is ultimately the responsibility of the Undersigned. It is further agreed by the Undersigned that in the event of any monies received by Provider from the insurance carrier are at any time after their receipt withdrawn from Provider by the insurance carrier, the Undersigned will be responsible for those monies then due and owing, and waives and defense for payment the Undersigned may have against Provider. In the event this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court cost but including reasonable attorney's fees. The Undersigned and/or Patient authorize use of this form of all insurance claim submissions. Your signature indicates you have read the above and agree to the terms contained therein. This agreement is irrevocable.

Responsible Party Signature:____ Date:____________________

1035 Park Boulevard Suite 2B • Massapequa Park, NY 11762 • Tel: 516.799.8599 • Fax: 516.799.4054 • neuropsychlongisland.org

OCR HIPAA Privacy
December 3, 2002
Revised April 3, 2003

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- Health Plans must also:
  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- Covered Direct Treatment Providers must also:
  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
  - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR

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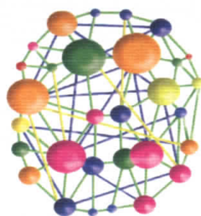

Neurorehabilitation & Neuropsychological Services

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I received health care services.

______________________________ ____________________
Signature Date

If you are not the patient and/or the patient is under 18 years of age, please fill out the following information

Name: ______________________________

Relationship to Patient: ______________________________

Address: ______________________________

Telephone Number: ______________________________

If applicable, please furnish a copy of any conservator/guardianship papers with this form

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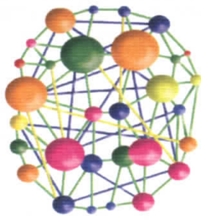

Neurorehabilitation & Neuropsychological Services

Authorization for Release of Health Information

I, ____ ________________________________
(Print full name) (Date of Birth)

Hereby authorize the release of my health information

From/To:
Neurorehabilitation and Neuropsychological Services, PC
1035 Park Blvd #2B
Massapequa Park, NY 11762

From/To:
Name:____
Address: ____
City, State, Zip: ____

- □ In/Outpatient Treatment Records/Progress Notes
- □ Admission/Discharge Summaries
- □ Consultant Reports
- □ Neurological Consultations/Testing (i.e. MRI, EEG, CT Reports)
- □ Psychological or Psychiatric Evaluations, Reports, Treatment Notes, Summaries (excluding psychotherapy notes)
- □ Other (Specify): ____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of Disclosure:
- □ Continuity of treatment
- □ Assessment & Evaluation
- □ Legal
- □ Patient's request
- □ Other: ____

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the last date of service. The requestor should not redisclose my medical record to another party without further written consent.

I will not hold Neurorehabilitation and Neuropsychological Services, PC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Neurorehabilitation and Neuropsychological Services, PC for clarification of the information therein.

Signature: ____ Date:______________________

Witness: ____ Date:______________________

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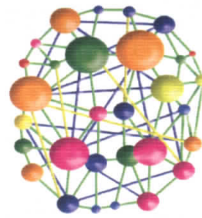

Neurorehabilitation & Neuropsychological Services

Neuropsychological Technicians

In our practice, we use neuropsychological technicians to help patients have greater ease of access to neuropsychological testing services.

What is a neuropsychology technician?
Neuropsychological technicians are professionals with at least a Bachelor's degree in psychology or related field who have undergone specialized training in order to administer and score neuropsychological examinations and to work with patients in this practice. They are analogous to medical technicians who are specialized in providing patient services such as radiologists and phlebotomists. The role of the neuropsychological technician is to collect and process neuropsychological data. All neuropsychological test selection, interpretation of neuropsychological assessments, diagnoses and treatment recommendations are made by licensed neuropsychologists.

Our neuropsychology technicians
Each of our neuropsychology technicians holds at least a Master's degree in psychology, which exceeds the training standards required by New York State. They are trained to administer and score neuropsychological tests to the same level as a neuropsychologist. They work under the direct and close supervision of our licensed neuropsychologists and receive ongoing training in order to help provide excellence and greater flexibility in neuropsychological services.

Should you choose, you can opt out of having a neuropsychology technician administer neuropsychological tests. Please be aware however, that this may result in less flexibility in scheduling your testing appointments as it will depend on the availability of a neuropsychologist.

Please indicate one of the following:

________ I agree to have a neuropsychology technician involved in the administration of neuropsychological tests for me/ my child.

________ I decline the services of a neuropsychology technician.

Name of patient:________________________

________________________________ Signature of patient/ guardian

________________________ Date

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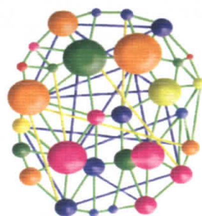

Neurorehabilitation & Neuropsychological Services

Patient History Questionnaire

Please fill out the following questionnaire to the best of your ability. Take note that if you are a parent, bringing your child to Neurorehabilitation and Neuropsychological Services, PC for an evaluation or treatment, the questions below pertain to your child unless otherwise specified. If a question is not applicable to you or your child, please write N/A in that space. Thank you for your thoroughness and attention to detail, as this helps us to serve you more effectively.

Name of Patient: ______________________ Date: ______________________
DOB: ______________________ Handedness: ______________________

Referral Source: ______________________ PCP: ______________________

IF CHILD
Mother's Name: ______________________ Place of Employment: ____________
Father's Name: ______________________ Place of Employment: ____________

Presenting Symptoms

Please list all current symptoms

Complaint/Symptom	Length of time experienced

What therapies or treatments have you tried to address these problems?

____
____
____
____
____

Medical History

Please list all medical conditions for which you (or the patient) is being treated

Condition	Treating Clinician	Year Diagnosed

Please list your current medications

Medication (dosage)	Why is it prescribed?	Percieved Efficacy (0-5, 5=very effective)

Please list previous surgeries

Surgery	Year of Procedure	Complications?

Sleep (check all that apply)

Do you:
- ☐ Have difficulty falling asleep?
- ☐ Problems maintaining sleep?
- ☐ Have restless leg syndrome?
- ☐ Walk in sleep?
- ☐ Dream vividly?
- ☐ Sleep Apnea?
- ☐ Talk in sleep?
- ☐ Experience nightmares?
- ☐ Wake too early in the morning?

If you have checked "yes" to any of the above, please explain below in greater detail

____

____

____

____

Headaches

Do you experience frequent or persistant headaches? ☐ Yes ☐ No

If yes: What time of day______________________

Where are they located?______________________

Rate pain on 1-10 scale (10=excruciating):______________________

Patient History Questionnaire

Medical History contd.

Head Trauma

Have you experienced any head trauma? ☐ Yes ☐ No

Loss of consciousness? ☐Yes ☐ No

Please explain below for each instance of head trauma or loss of consciousness

Date of Injury	Reason (i.e. car accident, sports, loss of oxygen, seizure)	Time unconscious	Headaches?	How long?	Confusion?	How long?	Memory Loss?	How long?
			☐ Y ☐ N		☐ Y ☐ N		☐ Y ☐ N	
			☐ Y ☐ N		☐ Y ☐ N		☐ Y ☐ N	
			☐ Y ☐ N		☐ Y ☐ N		☐ Y ☐ N	
			☐ Y ☐ N		☐ Y ☐ N		☐ Y ☐ N	

Head injuries which required hospitilization (specify how long):____________________

____

____

____

____

If a sports injury, did your injury require your removal from the sport? ☐ Yes ☐ No

For how long?____________________

Are you involved in a legal case regarding your head injury? ☐ Yes ☐ No

If yes, please specify: ____________________

____

____

Social and Vocational History (for adult patients)

Where do you live?____________________

Are you: ☐ Single ☐ In a committed relationship ☐ Married

If in a committed relationship or married, how long?____________________

How many times have you been married?____________________

Your spouse?____________________

Where were you reared?____________________

How many siblings were reared in your home along with you?____________________

Who raised you? (check all that apply) ☐ Biological Mother ☐ Biological Father ☐ Stepmother ☐ Stepfather ☐ Adoptive Parents ☐ Grandparents ☐ Other(s)____________________

What is your current job or occupation?____________________

How long have you done this job/worked for this company?____________________

Do you find your work environment to be supportive of you?____________________

Do you enjoy your job?____________________

What is the most difficult aspect of your job?____________________

Do you receive Social Security Disability Services? ☐ Yes ☐ No

What year did you first receive DDSSA services?____________________

For what reason?____________________

Social and Vocational History contd. (for adult patients)

Vocational and/or Military History

Employer/ Branch of Military	Position/ Rank	Dates Employed/ In Service	Reason for Leaving/ Discharge

Academic History

If a student, where do you (or the patient) attend school?____________________

What grade/year?____________________

How many years of school have you (or the patient) completed?____________________

What did/do you (or the patient) struggle with during school? (e.g. particular subjects, attention/focus, behavior):____________________

School History

School	Grade(s)/Years Attended	Average Grades	Difficulties/IEP/504?

Developmental History

Patient's Gestational Period	Yes / No	Please Explain
Was the Patient's mother under the care of a physician?	☐ Y ☐ N	
Did the mother experience any health issues during the pregnancy?	☐ Y ☐ N	
Threatened early delivery?	☐ Y ☐ N	
Substance abuse during pregnancy?	☐ Y ☐ N	
Problems with birth? APGAR score?	☐ Y ☐ N	
Medical issues at/after birth?	☐ Y ☐ N	
Additional instruments used at birth?	☐ Y ☐ N	

Patient History Questionnaire

Developmental History contd.

Did the patient experience problems/delays with any of the following:

Activity/Item	Yes / No	Please describe	Any therapies recieved?
Holding head up	☐ Y ☐ N		
Turning over	☐ Y ☐ N		
Sitting	☐ Y ☐ N		
Crawling	☐ Y ☐ N		
Walking	☐ Y ☐ N		
Riding a Bike	☐ Y ☐ N		
Using scissors	☐ Y ☐ N		
Learning to write	☐ Y ☐ N		
Talking	☐ Y ☐ N		
Dressing independently	☐ Y ☐ N		
Tantrums	☐ Y ☐ N		
Repetitive Behaviors	☐ Y ☐ N		
Clumsiness	☐ Y ☐ N		
Bedwetting/soiling clothes/constipation	☐ Y ☐ N		
Chronic Illnesses	☐ Y ☐ N		
Shyness	☐ Y ☐ N		
Daydreaming	☐ Y ☐ N		
Separation Anxiety (person/object)	☐ Y ☐ N		
Sensory sensitivity	☐ Y ☐ N		
Social immaturity	☐ Y ☐ N		
Restricted range of interest	☐ Y ☐ N		
Allergies	☐ Y ☐ N		
Asthma	☐ Y ☐ N		
Tics	☐ Y ☐ N		
Seizures	☐ Y ☐ N		
Self-soothing behaviors	☐ Y ☐ N		
PE Tube placement	☐ Y ☐ N		

Mental Health History

Have you (or patient) ever been evaluated by a mental health professional for: ☐ A mental illness or condition?
☐ A substance abuse issue?
☐ A learning disability?

If you checked any of the above, please explain: ____________________

Please select and describe any mental health treatment you (or the patient) have received during your lifetime.

☐ Counseling/Psychotherapy ☐ Medication for depression ☐ Medication for anxiety
☐ Medication for sleep ☐ Medication for stress ☐ Hospitalization
☐ Outpatient treatment ☐ Other: ____________________

If you checked any of the above, please explain: ____________________

Do you (or the patient) struggle with the following

Symptom/Condition	When	Explain
Depression		
Intense anxiety/ Nervous breakdown		
Obsessions or thoughts that will not leave your head		
Compulsions or routine "must-do" behaviors		
Unusual fears or phobias		
Suicidal or Homicidal thoughts or behaviors		
Gambling		
Impulsive shopping		
Restrictive or binge eating		
Personality disorder		
Substance abuse/addiction		

Have you (or the patient) ever experienced a psychological trauma (e.g. rape, sexual abuse, etc)? ☐ Yes ☐ No
If yes, please explain: ____________________

Do you drink alcohol? ☐ Yes ☐ No
How much?____________________(drinks/week)
In the past, have you used alcohol more frequently? ☐ Yes ☐ No When? ____________
How much?__________(drinks/week)

Do you drink caffeine? ☐ Yes ☐ No
How much daily?____________________
In the past, have you used caffeine more frequently? ☐ Yes ☐ No When? ____________
How much?__________(daily)

Patient History Questionnaire

Mental Health History contd.

Do you use tobacco products now? ☐ Yes ☐ No

How much?______________________ via (e.g cigarettes, smokeless, etc)______________________

In the past, have you used tobacco more frequently? ☐ Yes ☐ No When? ______________

How much?______________________

Family System and History

Parents

Marital Status of parents (choose one) ☐ Married ☐ Separated ☐ Divorced ☐ Never married

If Divorced: ☐ Father Remarried ☐ Mother Remarried ☐ Neither parent has remarried

What age did your (or the patient's) parents divorce?______________________

If Parents have remarried: Name of Father's spouse:______________________

Name of Mother's spouse:______________________

Siblings

Name of Sibling	Age	Describe your (or patient's) relationship

Members of Household in which Patient lives

Name	Age	Relationship with Patient

Please check all that apply

Area	Mother	Father	Siblings	Maternal	Fraternal
Learning issues					
ADHD					
Depression					
Anxiety					
OCD					
Other mental issues					
Seizures					
Dementia/Neurological problems					
Tourettes					
Autoimmune disease					
Other:					

My signature below acknowledges that I have completed this survey and that all answers are correct to the best of my knowledge.

Signature:______________________________________ Date:______________________

APPOINTMENT & CANCELLATION POLICY

BY APPOINTMENT ONLY

NeuroRehabilitation and Neuropsychological Services, P.C. sees patients by appointment only. We make every effort to provide prompt care to all of our patients. **If you arrive in our clinic as a walk-in, please understand that you will be asked to schedule an appointment for a different time.**

It is your responsibility to know when your next appointment is scheduled. You may request a reminder call as a courtesy; how ever, the responsibility of remembering your appointment is still yours regardless of whether or not we are able to reach you by phone.

LATE ARRIVALS

Our office will make every effort to maintain appointment time commitments and we req uest that you
extend the same courtesy to us. If you are running late, please call our clinic to reschedule. We understand that special circumstances can arise, which may cause you to run a few minutes behind. On occasion we are able to work-in late arrivals however; this is at the discretion of our front office staff. **If you are more than 15 minutes late we may ask you to** reschedule to help avoid delays in treatment

MISSED APPOINTMENTS (NO SHOWS)

The staff at NeuroRehabilitation and Neuropsychological Services, P.C. respects your time and we ask for the same courtesy. Missed appointments (no shows) affect our ability to provide timely attention to our patients. When a patient does not show up for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our clinic at least 24 hours in advance. Failure to cancel an appointment that you do not attend will be considered a missed appointment or no show.

Protocol for No Shows:

If you fail to attend a Testing appointment or a QEEG appointment, you will be charged a $50 no show fee. You are directly responsible for payment of the no show fee on or before your next appointment. The no show fee cannot be billed to your insurance company.

Patients (Guardian) signature: ______________________

Date: ________________