Neurobehavioral Consultants, P.C.

CHILD/MINOR PATIENT INFORMATION FORM

Patient Name: _____ _____ _____
First Middle Last

DOB: _____ Male _____ Female _____

Address: _____ Apt # _____ City: _____ State: _____ Zip Code: _____

PARENT(S) / GUARDIAN INFORMATION

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Patient's ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance Company: _____ Patient's ID: _____

Subscriber Name: _____ Subscriber DOB: _____

_____ _____ _____
*Signature Date Relationship to Patient

_____ _____ _____
Print Name Print Patient's Name Patient's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the patient, then both parent's signatures are required. Only one parent's signature is required if parents are married.

_____ _____ _____
Additional Parent Signature Date Relationship to Patient

_____
Print Name

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
(248) 723-9200 • Fax (248) 723-9218 • admin@nbcmanager.com

PATIENT SERVICES AGREEMENT

This document contains important information about our business and privacy policies. Your signature acknowledges that we have provided you with this information prior to your first session. Please read this document carefully before signing. While you may revoke this agreement in writing at any time, such revocation will not apply to services already rendered, nor will it prevent us from meeting obligations imposed on us by your heath insurer in order to process or substantiate claims made under your policy.

PROFESSIONAL FEES: In addition to the fees for weekly appointments and neuropsychological testing services, you may be billed at an hourly rate for other professional services requested by you or your team, such as: letters, forms and reports, communication with professionals, telephone services, and records reviews. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time, even if we are called to testify by another party.

PAYMENT AND BILLING: Your insurance company will be billed for services provided. We must have complete and accurate insurance information in order to bill for services. You are responsible for any fees that are not covered by insurance, unless prohibited by provider agreement with your insurance company. If you have questions about your coverage, you should contact your insurance company directly.

Co-payments, deductibles, and coinsurance payments are due at the time of service. We accept cash, checks, Visa, Mastercard, Discover, and American Express.

CANCELLATION POLICY: No shows and late cancellations negatively impact our ability to serve you and other patients. We will charge a $100 cancellation fee for appointments cancelled without at least 24-hour notice. The fee for cancelling a testing day without 48-hour notice is $500. If you repeatedly miss scheduled appointments, you may be removed from regularly scheduled appointment times.

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that protects the privacy and security of all communications between a patient and provider. As a patient, you have the right to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, this Notice will describe the ways in which we may use and disclose medical information about you. We will describe your rights and the obligations we have regarding the use and disclosure of medical information.

We may use and disclose your medical records only for each of the following purposes:

- **Treatment:** Providing, coordinating, or managing health care and related services by one or more healthcare providers. We keep records during treatment to ensure quality care and legal compliance. Examples include psychotherapy records, evaluation reports, and contacting you to provide appointment reminders and information pertaining to your treatment.

- **Payment:** Obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health Care Operations**: The business aspects of our practice, such as conducting quality assessment and improvements activities, auditing functions, cost-management analysis, and customer service.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing. We will abide with your revocation except to the extent that we have already taken actions relying on your authorization.

PATIENT RIGHTS

HIPAA provides expanded rights regarding Protected Health Information (PHI). You can provide a written request to:

- Request restrictions on what information in your Clinical Record is disclosed to others.
- Receive an accounting disclosure of PHI and where they were sent.
- Inspect and copy your PHI.
- Amend your PHI.
- Receive a written copy of this Notice from us upon request.

If you feel that your privacy protection has been violated, you have the right to file a written complaint with our office or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain requirements imposed by HIPAA.

There are some situations in which we are permitted or required to disclose information without authorization:

- If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is often protected by the psychologist-client privilege law. We may provide information with your written authorization or a court order. If this may be applicable to you, you should consult with your attorney about likely required court disclosures.
- If a government agency is requesting the information for health oversight activities.
- If a patient files a complaint or lawsuit against our office, we may disclose relevant information in our defense.
- If a patient files a worker's compensation claim, and we are providing treatment related to the claim, we must, upon appropriate request, furnish copies of all reports and bills.
- If we believe an individual is the victim of abuse, neglect, domestic violence, or exploitation, we are legally obligated to take action and file a report with the appropriate government agency. If we determine that a patient presents a serious danger of violence to others, we may be required to take protective actions. Such actions may include notifying the potential victim(s), contacting the police, and/or seeking hospitalization for the patient. If such situations arise, we will make every effort to fully discuss it with you before taking action and will limit our disclosure to what is necessary.

Neurobehavioral Consultants, P.C.

OFFICE FILE COPY

Your signature below indicates that you have read the Patient Services Agreement and that you agree to its terms. It also serves as acknowledgement that you have received the HIPAA notice.

_____ _____

*SIGNATURE DATE

_____ _____

PRINT NAME RELATIONSHIP TO PATIENT

_____ _____

PRINT PATIENT'S NAME PATIENT'S DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parent's signatures are required.

Only one parent's signature is required if parents are married to each other.

_____ _____

Additional Parent Signature Date

_____ _____

Print Name Relationship to Patient

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
(248) 723-9200 • Fax (248) 723-9218 • admin@nbcmanager.com

Neurobehavioral Consultants, P.C.

HANDLING OF CONFIDENTIAL HEALTH INFORMATION

Communication by Email:

Neurobehavioral Consultants, P.C. cannot guarantee confidentiality with electronic communications. It is important that you understand that the nature of the internet is that any emails you send or receive may also be intercepted by other people. Neurobehavioral Consultants, P.C. uses an encrypted email server, but recipient email address typically do not (Yahoo, Gmail, Hotmail, AOL, Comcast etc.) There is an inherent risk to using any unencrypted communication.

After reading the above information, may we communicate with you by email? YES NO

TeleMedicine:

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect confidentiality of my medical information also applies to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive expectations to confidentiality including, but limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in legal proceeding.
3. Although Neurobehavioral Consultants, P.C. uses HIPAA compliant software, I understand that there are risks and consequences from telemedicine including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could accessed by unauthorized persons.
4. I understand that telemedicine-based services and care may not be as complete as face-to-face services. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
5. By signing this document I agree that certain situations, including emergencies and crises, are Inappropriate for audio/visual/computer based psychotherapy services. If I am in a crisis or in an Emergency, I should immediately call 911 or go to the nearest hospital.

I have read and understand the information provided above.

*SIGNATURE	DATE	RELATIONSHIP TO PATIENT
PRINT NAME	PRINT PATIENT'S NAME	PATIENT'S DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parents signatures are required. Only one parent's signature is required if parents are married to each other.

ADDITIONAL PARENT'S SIGNATURE	DATE	RELATIONSHIP TO PATIENT
PRINT NAME		

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
(248) 723-9200 • Fax (248) 723-9218 • admin@nbcmanager.com

Neurobehavioral Consultants, P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I hereby authorize Dr. Jay Inwald and/or Neurobehavioral Consultants, P.C., at 31600 Telegraph Rd., Suite 230, Bingham Farms, MI 48025, to obtain and or release any medical, psychiatric, educational, or psychological information to:

Please list all the individuals/organizations to whom you would like your Neuropsychological Evaluation Report to be sent: **IF NO PARTY IS LISTED BELOW, THE REPORT WILL BE RELEASED ONLY TO THE PATIENT AND THE REFERRAL SOURCE PROVIDED AT THE TIME OF SCHEDULING.**

NAME: ADDRESS/FAX #/PHONE #:

_____

_____

_____

_____

I hereby consent to the release of medical, psychiatric, educational, or psychological information, which may include drug abuse and mental health records obtained in the course of my diagnosis, assessment, and or treatment. I understand that such information cannot be released without my specific consent, except in a medical emergency or by court order.

I have read and fully understand its contents. I have asked questions about anything that is not was not clear to me and I am satisfied with the answers I have received.

I agree that the photocopy of this Release may be accepted, if necessary. This authorization is valid until revoked in writing.

_____ _____ _____

Signature* Date Relationship to Patient

_____ _____ _____

Print Name Print Patient's Name Patient's DOB

If parents are **separated or divorced and have **joint custody** of the client, then both parent's signatures are required. Only one parent's signature is required if parents are married.

_____ _____ _____

Additional Parent Signature Date Relationship to Patient

_____

Print Name

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
(248) 723-9200 • Fax (248) 723-9218 • admin@nbcmanager.com

Neurobehavioral Consultants, P.C.

31600 Telegraph Road, Suite 230
Bingham Farms, Michigan 48025

(248) 723-9200
Fax (248) 723-9218

Name: _____ Date of Birth: _____ Parents: _____

Pediatrician/Family Physician: _____ Current Medication(s): _____

PROBLEMS (Observed/Reported)

Please indicate any problems that your child is **currently having** or has had within the **past six months** only.

LIST 1	
Annoying Behavior (seems intentional)	
Argumentative	
Avoidance (e.g. people, places, activities)	
Binge Eating	
Blames Others	
Controlling	
Deceitful	
Defiance	
Difficulty Concentrating	
Difficulty Organizing	
Diminished Appetite	
Disturbed Body Perception	
Easily Distracted	
Energy Changes	
Excessive or Intense Fears	
Fasting	
Fatigue	
Feelings of Guilt or Worthlessness	
Flight of Ideas	
Hyperactive	
Hyper-Vigilance	
Immature For Age	
Inattentive	
Insomnia	
Interrupts	
Irritability	
Labile	
Lack of Empathy	
Little or No Motivation	
Loss of Temper	
Low Self-Esteem	
Memory Loss	
Motor Restlessness	
Oppositional	
Perfectionism	
Poor Social Skills	
Restricted Emotional Expression	
Sadness	
Social/Occupational Dysfunction	
Suspiciousness	
Talks Excessively	
Tics	
Unable to Follow Directions	
Use of Laxatives, Diuretics, Appetite Suppressants	
Worry	

LIST 2	
Accident Prone	
Aggression	
Anxiety	
Body Weight Less Than 85% of Normal	
Depression	
Destruction of Property	
Detachment	
Disorganized Speech	
Excessive Interest (In One Thing or Idea, e.g. dinosaurs, trucks, Middles Ages)	
Impaired Communication (e.g. Delay/Lack of Spoken Language, Repetitive/Idiosyncratic Language)	
Impaired Social Interaction (e.g. No Eye Contact, Blank Facial Expression)	
Impulsivity	
Inflated Self Esteem or Grandiosity	
Irrational Fears (Death, Loss of Control)	
Low Frustration Tolerance	
Mania	
Perceptual or Cognitive Distortion	
Promiscuity	
Purging, Self-Induced Vomiting	
Repetitive Behavior (Hand Washing, Counting)	
Repetitive/Stereotypical Behaviors	
Restrictive Eating	
Serious Violation of Rules (Truancy, Run Away)	
Significant Weight Change	
Sleep Difficulties (Explain)	
Somatic Complaints	
Theft	

LIST 3	
Delusions	
Disorganized Behavior	
Dissociation	
Flashbacks	
Hallucinations	
Mood Swings	
Recurrent, Persistent Intrusive Thoughts	
Repeats Words or Stock Phrases	
Self-Harm (Cutting)	
Thoughts of Death	
Use of Weapons (Excessively)	
Violence	
Other:	

Neurobehavioral Consultants, P.C.

Child's History

Please fill out this questionnaire as fully as possible. If you have any questions, you can discuss them with the examiner when the history form is reviewed with you.

Child's Information

Name:_____ Birth Date:_____ Age:_____

Address:_____ Phone:_____

City:_____ Zip Code:_____

Parent/Guardian Name:_____

Parent/Guardian Address:_____

Parent/Guardian Phone:_____

What are the problems that cause you to seek help for this child? (Be specific)_____

_____

_____

Referring Doctor:_____ Phone:_____

Adults in the home:_____

Relationship to child:_____

Is this child adopted?_____ If so, age at adoption:_____

Status of parent's marriage:_____

	Birth Mother	Birth Father
Age:		
Highest Grade Completed:		
Diploma/Degree:		
Occupation:		
Learning Difficulty:		
Behavioral Problems:		
Emotional Problems:		

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
(248) 723-9200 • Fax (248) 723-9218 • admin@nbcmanager.com

Siblings (including step-siblings and half siblings):

Name	Age	Sex	In the home?

Birth and Developmental History

PREGNANCY

Prenatal Care _____Yes _____No

Please describe any complications that occurred during the pregnancy:_____

_____

_____

Substances used **during** the pregnancy?

_____ Cigarettes How many? _____Per day:_____ Per Week:_____
_____ Alcohol How much?_____ Per day:_____ Per Week:_____
_____ Drugs Type and frequency:_____
_____ Medications Type and frequency:_____

LABOR AND DELIVERY

Mother's age at time of birth:_____ Father's age at time of birth:_____

Was the birth premature?_____ If so, how early:_____

Birth weight:_____ Length:_____ APGAR scores:_____

Was this a feet first (breech) delivery?_____ Did you have a Cesarean delivery?_____

Please describe any complications with the delivery:_____

_____

Please describe any health problems the baby had:_____

_____

How long did the child stay in the hospital?_____

Was oxygen used for the baby? ____Yes ____No

Ages at Milestones

Crawled:_____ Walked:_____ Ran Well:_____

Fed Self With Spoon:_____. Scribbled:_____Tied Shoes:_____Ride Two Wheeler:_____

Used Single Words:_____ Used Sentences (2+words):_____ Described Activity:_____

Potty Trained/Day:_____ Potty Trained/Night:_____

Rate of Development Overall: _____ Slow _____ Normal _____ Fast

Medical History

Please describe any serious injuries, illnesses, and/or surgeries your child has had:_____

_____

_____

Has the child had a head injury?_____ If so, did he/she lose consciousness?_____

If he/she lost consciousness, for how long?_____ Was he/she comatose?_____

Please describe any other handicapping conditions or special health considerations and their treatments:_____

_____

Date and results of last hearing test:_____

Date and results of last vision test:_____

Please list medications (with dosage and times) currently being taken by the child, including non-prescription medications:_____

_____

_____

BEHAVIORAL AND MENTAL HEALTH HISTORY

Please describe any professional mental health treatment, such as individual, family, or group counseling, that your child has received. Please list name of the counselor, type of treatment, and length of treatment._____

_____

_____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments. Please feel free to use the back of this page if more room is needed._____

_____

_____

EDUCATIONAL HISTORY

Please list the name, location, type of program, number of days per week, age when started, and how your child progressed in preschool and/or daycare programs:_____

_____

_____

Current grade and school:_____

Previous schools attended and grades at each:_____

_____

Briefly describe the child's performance academically and socially in each grade:

Kindergarten:_____

1st Grade:_____

2nd Grade:_____

3rd Grade:_____

4th Grade:_____

5th Grade:_____

Middle School:_____

High School:_____

_____

_____

Has the child been placed in special education programs currently or in the past?_____

_____ Learning Disability (LD): Subjects:_____

_____ Language Disorder: Type:_____

_____ Tutoring: Subjects:_____

Previous Psychosocial Testing:_____

FAMILY HISTORY

For the following questions, please consider the child's parents, siblings, grandparents, uncles, aunts, and cousins).

Please indicate which family members experience the following problems: inattentiveness or hyperactivity; epilepsy; migraines; alcoholism or substance abuse; anxiety, depression, learning problems, developmental disabilities, neurological disorders, or other psychological, emotional and/or personality difficulties:

Mother's side: _____

_____

Father's side: _____

_____

Please add any additional comments you think might be helpful: _____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Signature* Date Relationship to Patient

_____ _____ _____

Print Name Print Patient's Name Patient's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parent's signatures are required. Only one parent's signature is required if parents are married to each other.

_____ _____ _____

Additional Parent Signature Date Relationship to Patient

_____

Print Name

Neurobehavioral Consultants, P.C.

DIRECTIONS

Address:
31600 Telegraph Rd. Suite 230
Bingham Farms, MI 48025

Phone: 248.723.9200

PLEASE NOTE:

- We are located North of 13 Mile Road on the East side of Telegraph Road.
- Once you have passed 13 Mile Road our office building will be on the **East side** of the road. You will see a **black sign** with **white trim** and with an **orange brick bottom**. The complex is called **GEORGETOWN.**
- Turn **RIGHT** into the complex **GO ALL THE WAY TO THE STOP SIGN** then turn **RIGHT**.
- **WE ARE NOT THE BUILDING THAT FACES TELEGRAPH ROAD.**

Neurobehavioral Consultants, P.C.

CREDIT CARD AUTHORIZATION

Because it is not always possible to collect payments from clients at the time of service, we request that you provide us with a credit card number to keep on file.

By signing below, I authorize that the credit card on file may be charged for co-pays, co-insurance or deductible payments, charges for out of pocket sessions, and any balances due at the end of the month after insurance payments have been posted to your account.

By signing below, I certify that the information provided is true and accurate and that I am an authorized user on the credit card/debit card account provided below. I authorize Neurobehavioral Consultants, P.C. to keep my credit card information on file and charge the amounts due automatically on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for notifying Neurobehavioral Consultants, P.C. if my credit/debit card information needs to be updated.

_____

PATIENT'S NAME

_____

CARDHOLDER NAME

_____

BILLING ADDRESS

_____

CITY STATE ZIP

CIRCLE CREDIT CARD TYPE:

MASTERCARD VISA AMERICAN EXPRESS DISCOVER

_____

CREDIT CARD NUMBER

_____

EXPIRATION DATE CV-CODE

_____

CARDHOLDERS SIGNATURE

_____

DATE

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
(248) 723-9200 • Fax (248) 723-9218 • admin@nbcmanager.com