Consent for Neuropsychological Evaluation

I understand that I am being seen for a neuropsychological evaluation. The evaluation may include an interview, record review, and testing with various measures of attention, motivation, motor and sensory abilities, language and spatial skills, problem solving, memory, intellectual functioning, and emotional or personality functioning. I may request further information about any of these procedures.

This evaluation is scheduled for a full day, but I will be allowed breaks as needed. Feedback will be provided at the completion of testing, or arrangements will be made to provide feedback at a later date.

I am welcome and encouraged (but not required) to bring my husband/wife/spouse or significant other to the interview and feedback sessions.

I understand and agree with the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Guardian Date

CHILD/ADOLESCENT NEUROBEHAVIORAL HISTORY FORM

_____

Patient Name

_____

Date Completed

_____

Completed By

It is very important to understand an individual's history to formulate a complete understanding of symptoms and identify a specific diagnosis. Although this form is quite long, your taking time to respond to the questions, providing complete, accurate responses will greatly help in understanding the symptoms you may be experiencing. This will also help to identify the most appropriate treatment plans and strategies.

For many problems, there is often a genetic family history, as many problems are inherited (e.g., depression, learning problems, anxiety disorders).

Please complete this form and bring it with you to your appointment.

I. DEMOGRAPHIC & REFERRAL INFORMATION

Full Legal Name:_____ Date of Birth:_____ Sex: ☐M ☐F

Mailing Address: _____

Home Ph:_____ Work Ph:_____ Cell Ph: _____

Email Address:_____ SSN: _____

Referred By:_____ Phone: _____

_____

What is your understanding of the reason for referral? _____

Give a brief history of the symptoms leading to this referral, (i.e. onset to present):

_____

_____

On the scale below, how would you rate the severity of the symptoms connected to this referral?

☐Mildly Upsetting ☐Moderately ☐Severe ☐Very Severe ☐Extremely Severe ☐Totally Incapacitating

II. FAMILY INFORMATION

CHILDREN IN FAMILY, (please list biological, step and/or adopted)

NAME	AGE	SEX	GRADE	HOW IS SCHOOL GOING

OTHER PEOPLE IN THE HOUSEHOLD

NAME	AGE	SEX	EDUCATION	RELATIONSHIP TO PATIENT

	PARENTS NAME	AGE	OCCUPATION	RACE	DECEASED
Mother					☐Y☐N
Father					☐Y☐N
Stepmother					☐Y☐N
Stepfather					☐Y☐N
Legal Guardian					☐Y☐N

SIBLINGS

NAME	AGE	SEX	EDUCATION (IN YRS)	DECEASED
_____	_____	_____	_____	☐Y☐ N
_____	_____	_____	_____	☐Y☐ N
_____	_____	_____	_____	☐Y☐N

III. DEVELOPMENTAL HISTORY

Place of Birth:_____Birth weight: (if known)_____Birth Length: _____
Complications at birth?_____
Did your mother smoke, drink, or use drugs during pregnancy? ☐Yes ☐No
If yes, what and how much?_____
As a child did you/do you have any of the following?

☐Premature Birth ☐Meningitis ☐High Fevers
☐Low Birth Weight ☐Seizures ☐Birth Defects
☐Birth Complications/Injury ☐Recurrent Ear Infections ☐Hearing Problems
☐Vision problems ☐Asthma ☐Bed-wetting
☐Other _____

Which is your dominant hand? ☐R ☐L ☐Ambidextrous
Have you:

☐Been physically assaulted
By whom_____For how long/how many times_____
Treated for_____

☐Been sexually abused
By whom_____For how long/how many times_____
Treated for_____

IV. FAMILY HISTORY

ANY FAMILY MEMBERS WITH THE FOLLOWING PROBLEMS?
(Family defined as brothers, sisters, parents, grandparents, aunts, and uncles).

Condition	Relation
Learning Problems:	_____
Depression:	_____
Alcoholism/Drug Addition:	_____
Epilepsy:	_____
Mental Retardation:	_____
Trouble with the law:	_____
Hyperactivity:	_____
Anxious or perfectionist:	_____
Speech or hearing problems:	_____
TIC behaviors or nervous habits:	_____
Psychiatric hospitalization:	_____

Other behavior or emotional problems: _____

Family history of left-handedness? _____

Any major health problems diagnosed in your immediate or extended family (e.g. diabetes, heart disease, high blood pressure, stroke)?

_____

V. HEALTHCARE HISTORY

Primary Care Physician: _____ Phone:_____
Do you want us to send report of this assessment? ☐Yes ☐No

Do you see a dentist? ☐Yes ☐No Are there dental problems? ☐Yes ☐No

Do you regularly see any other physician/therapist than your primary physician ? ☐Yes ☐No
If yes, Who?_____

Have you ever been treated for any psychiatric or behavioral disorder (e.g., ADHD, substance abuse, depression)? ☐Yes ☐No If yes, please list the disorder, dates, and any medication prescribed:

_____

_____

Have you ever had any of the following?

☐Head Injury (TBI)
☐Automobile Accident(s)
☐Neurological Disease or Injury
☐Heart Problems
☐Near Drowning
☐Alcohol/Substance Abuse
☐High Blood Pressure
☐Heart disease
☐Cancer
☐Blood disorder
☐Visual Problems
☐Serious Infection
☐Meningitis
☐Encephalitis
☐Other _____

☐Diabetes
☐Liver or Kidney disease
☐Stroke
☐Prescription Drug Abuse
☐Hospitalizations
☐Poisoning
☐Toxic Exposures
☐Headaches
☐Paralysis
☐Deafness/hearing loss
☐Back/Neck injury
☐"Nervous Breakdown"
☐High Fever
☐Seizures

Medications you currently take:

Medication	Dose (Mg)	How taken (e.g. two times daily, three times daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Height _____Weight _____

Do you currently smoke? ☐Yes ☐No How much? _____ When did you start? _____
If no, have you ever smoked? ☐Yes ☐No How long since you stopped smoking? _____

Do you currently drink alcohol? ☐Yes ☐No Number of drinks per occasion _____
If no, have you ever drank? ☐Yes ☐No
Has your alcohol use ever caused problems? ☐Yes ☐No Explain _____

Do you (or have you) use "recreational" drugs (e.g., marijuana, cocaine, crack)? ☐Yes ☐No Explain:

_____

Have you ever been addicted to prescription drugs? ☐Yes ☐No Explain:

_____

Please check any you have experienced or are experiencing now:

☐Headaches	☐Dizziness	☐Fainting Spells
☐Rapid Heart Beat	☐Stomach Trouble	☐No Appetite
☐Bowel Disturbances	☐Fatigue	☐Insomnia
☐Nightmares	☐Can't Stay Asleep	☐Overeating
☐Feel Tense or Anxious	☐Feel panicky	☐Tremors/Shaky
☐Depressed	☐Suicidal	☐Unusually Extreme Temper
☐Unable to Relax	☐Sexual Problems	☐Shy with People
☐Don't Like Weekends/Vacations	☐Over Ambitious	☐Can't Make Decisions
☐Can't Make Friends	☐Inferiority problems	☐Home Conditions Uncomfortable
☐Can't Keep a Job	☐Memory problems	☐Unable to Have a Good Time
☐Financial Problems	☐Concentration Difficulties	☐Other
☐Sensitive to Light	☐Sensitive to Loud Noise	

VI. EDUCATIONAL HISTORY

1. List schools attended (public or private), grade school through high school:

School	Grades	City, State

Graduated High School? ☐Yes ☐No GED? ☐Yes ☐No
Estimated high school GPA: _____ Are school records available? _____
Extra-Curricular activities: _____

Education support required?

☐Started school late	☐Held back/repeated grade	☐Behavior problems
☐Resource/Spec. Ed	☐Underachiever	☐Learning Problems
☐Tutoring	☐Poor Motivation	☐Other: _____
☐Remedial Classes	☐Attention/Concentration Problems	

Please explain any of the above:

_____

_____

What, if anything, detracted from a successful school experience?

_____

Best and worst academic areas?

_____

VI. PERSONAL HISTORY

Have you ever been in trouble with the law? ☐Yes ☐No Explain:

_____

Hobbies: _____
Recreational Activities: _____
Areas of Interest: _____

_____

VII. DETAIL OF ACCIDENT/INJURY (IF APPLICABLE)

Date of accident/injury: _____
Details of accident/injury: _____
Loss of consciousness? ☐Yes ☐No Estimated length of unconsciousness? _____
Specific injuries: _____

_____

Which, if any, of the symptoms below have you experienced since your injury? If they were present before the injury but changed please explain below:

☐Nausea
☐Vomiting
☐Ringing in the ears
☐Blurred vision
☐Headache
☐Aggression
☐Decreased sexual drive
☐Fainting/blackouts
☐Memory Problems
☐Depression
☐Pain in chest
☐Anxiety
☐Decreased attention/concentration
☐Fatigue easily
☐Poor sleep
☐Decreased energy
☐Weight loss/gain
☐Difficulty with crowds
☐Mood swings
☐Hallucinations

Changes in:

☐Speech/Language ☐Reading ☐Math Skills ☐Thinking
☐Sense of Smell ☐Sense of Taste ☐Anger ☐Stress Tolerance
☐Frustration Tolerance

Limits of Confidentiality

Information discussed in the neuropsychological or psychological evaluation will be incorporated into the Neuropsychological (or Psychological) Evaluation report.

This report will be sent to the referring source and any other individuals/agencies identified on the Release of Information signed prior to the evaluation.

If the fee for this evaluation is being paid by an insurance company or other agency, it may be necessary to send a copy of the report to that agency to secure reimbursement, as noted in the signed Authorization for Payment of Benefits.

The client may request a report be sent to another person or agency at any time in the future by completing an additional Release of Information.

This report, and any other information discussed in the evaluation, is confidential, and it will not be shared without written permission except under the following conditions:

- The client threatens suicide.
- The client threatens harm to another person(s), including murder, assault, or other harm.
- The client reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
- The client reports abuse of the elderly.

State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies.

In addition, if the client is involved in a legal action and claims mental health issues related to the legal action (i.e., plea of "Not Guilty by Reason of Insanity," or claiming emotional harm in a lawsuit), mental health records may be required to be released.

Communications between Skip Hrin, PsyD, and the client will otherwise be deemed confidential as stated under **Alaska** state law.

Having read and understood the above, I agree to the limits of confidentiality.

_____ _____

Name of Client (and Guardian, if applicable) Date

_____ _____

Signature of Client Signature of Guardian

_____

Skip Hrin, PsyD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. Skip Hrin, PsyD, will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.

Your authorization: in addition to our use of your health information for treatment, payment, or health care operations, **you may give us additional written authorization** to use your health information or to disclose it to anyone for any purpose. **If you give us an authorization, you may revoke it in writing at any time.** Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family

member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, *but only if you agree that we may do so.*

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials: health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format.

Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

I hereby acknowledge receipt of Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

Printed Name:_____

Signature:_____