

The Memory Doctor, LLC
Douglas J. Mason, Psy.D., Licensed Clinical Psychologist
Neuropsychology, Forensics, & Clinical Psychology

Patient's Full Name _____

Parent/Legal Guardian (if patient's POA, please provide a copy) _____

Street Address _____

City, State, Zip Code _____

Social Security # _____ DOB _____

Home Phone # _____ Work # _____

Cell # _____ Email _____

Emergency Contact _____ Relationship _____ Phone # _____

May we call your home and leave a message? Yes No

May we call your cell and leave a message? Yes No

For emergencies, may we call you at work? Yes No

May we contact you by email? Yes No

Are you covered by workers compensation? Yes No

Are you involved in a law suit? Yes No

Are you covered by an insurance plan? Yes No

If yes, we require copies of your insurance card(s).

To be filled out by the **Responsible Party**, if other than the patient: (the person responsible for payment of all cost incurred or the Policy Holder of the insurance)

Full Name _____

Social Security # _____ DOB _____

Address _____

Home Phone # _____ Cell # _____

Responsible party's relationship to patient: () Self, () Spouse, () Child, () Parent

Privacy Notice: I acknowledge that I have read and understand the HIPAA Privacy Notice that is posted/provided in this office. A copy will be provided to me upon my request.

Patient or Responsible Party Signature

Date

The Memory Doctor, LLC
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Patient Registration

Name _____ **DOB** _____

Cancellation Policy: Please be advised that we require a 24-hour advance notice for all cancellations. Missed appointments and delinquent cancellations will be billed to you at your insurance rate. If I miss my appointment or if I cancel or miss 2 consecutive appointments all future appointments will be cancelled. I understand that I am responsible for paying the missed appointment fee prior to any future appointments.

Legal Issues: I understand that Dr. Mason does NOT participate in any legal issues (child custody, workers' comp, auto accidents, etc) unless an attorney or appropriate party has referred me **and** an evaluation and/or treatment is done for that purpose. All legal issues must be discussed and approved by our office prior to any type of medical/mental health services being rendered. I agree to pay for any fees associated with the legal aspects of my care.

Paperwork policy: Please note that most insurance companies will not reimburse us for completing paperwork. We reserve the right to charge for the completion of disability forms and other paperwork not relating to billing. This fee will cover the copying of records and faxing or mailing of original form. This processing fee will start at \$25 and will not exceed \$200 per incident and will depend on the paperwork required.

Returned Check Policy: There is a fee of \$25 payable in cash. All subsequent co-pays must be paid in cash.

Collection Policy: If my account is not paid according to terms, I understand that Dr. Mason's office reports to an outside collections agency. If my account is turned over to collections I agree to pay all additional fees assessed in the collection of the debt.

Insurance: This office will submit claims for insurance companies that we are contracted with. If we are not contracted with your insurance company we will provide you with a receipt that you may submit to your insurance company; however our fees are payable on the date the service is rendered. Please check your insurance carrier to determine if we are in network. It is the responsibility of the patient to know the terms of his/her insurance policies, including deductibles, covered and non-covered benefits, co-payments, etc. If any problems regarding insurance coverage should arise, it is your responsibility to rectify the problem. It is the patient's responsibility to inform the office of any changes in coverage at the time of service. This office will not file any insurance that becomes retroactively effective to services that have already been provided.

Assignment of Benefits/Release of Information: We cannot be responsible for any misinformation you provide us. Actual coverage information and any balances due cannot be accurately determined until an explanation of benefits is received from your insurance carrier. It is your responsibility to ensure all pre-authorizations or certifications are obtained prior to services being rendered. Co-pay, deductibles, and out of pocket expenses are due when services are rendered.

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned health professional. This assignment will remain in effect until revoked by me in writing. Sometimes an insurance company reimburses their insured a portion of the fee that is due to Dr. Mason. In the event that this occurs, I agree that within 5 days, I will remit payment to Dr. Mason. I understand that I am financially responsible for all charges whether or not paid by said insurance. If the time necessary for an evaluation or assessment exceeds that allotted by your insurance, I agree to assume financial responsibility for the difference. If my insurance company does not respond within 60 days from billed date, I will be responsible for contacting my insurance company to ensure payment. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

Patient or Responsible Party Signature

Date

The Memory Doctor, LLC
Douglas J. Mason, Psy.D., Licensed Clinical Psychologist
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Consent for Evaluation & Treatment

Name _____ **DOB** _____

I do hereby express my understanding that _____ is to receive psychological /neuropsychological services provided by Dr. Douglas J. Mason.

I understand that I have the option to decline the evaluation/treatment and to request a referral to a different service provider. I was referred by: _____

Limits of Evaluation/Therapy

I understand that psychology is an inexact science and that no guarantees are being made as to outcome or results. I further understand that psychological evaluation/therapy results may not be what I hoped they may be and that Dr. Mason will evaluate the data at hand as objectively as possible to formulate an accurate assessment and implement appropriate treatment. I will not hold Dr. Douglas J. Mason liable for any injury or harm, whether mental, physical, financial, legal, or medical as a direct or indirect result of assessment, evaluation, or treatment.

Limits of Confidentiality

I further understand that my privilege of confidential communication will be maintained by Dr. Mason with the following exceptions:

*Should there be an allegation of abuse or neglect (e.g. child, spousal or elder), Dr. Mason has an obligation to report any pertinent information to the proper authorities and may be asked to testify in court regarding that information and will be subpoenaed to do so.

*Should there be any expressed intention to harm another or oneself, Dr. Mason has an obligation to report this information to the appropriate authorities and to make a reasonable effort to prevent such an action and will do so.

*Should written request for **or** permission for the release of treatment information by provided by me; such information (mental health, alcohol/drugs, HIV/Aids) will be released to the professional individual, agency, or corporation as requested.

*Should there be a court order/subpoena to appear in front of a judge or if your records are requested by a subpoena or court order we must provide the requested records.

I authorize Dr. Mason to discuss my treatment with the following individuals:

I have read this Consent for Evaluation and I understand it fully and voluntarily sign:

Patient or Responsible Party Signature

Date

The Memory Doctor, LLC
Douglas J. Mason, Psy.D., Licensed Clinical Psychologist
Neuropsychology, Forensics, & Clinical Psychology

26540 Ace Avenue, Suite E
Leesburg, FL 34748
Phone 352-243-5901 Fax 352-243-4187

Authorization to Release or Use of Information for Treatment, Payment, or Health Care Operations

Patient Name: _____ DOB: _____

I hereby authorize **The Memory Doctor LLC/Douglas J. Mason, Psy.D.**, to release and/or obtain any and all of the information it possesses relating to my evaluation(s), treatment, and illness(es) including the psychiatric and psychological information which may be part of the medical records to the following individuals on my behalf:

Purpose: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

I give my permission for the information listed above to be shared between the above individuals. I understand that as per HIPAA my protected health information and medical information including the results of my Neuropsychological evaluation may be shared for continuity of care. Should there be a court order/subpoena to appear in front of a judge or if your records are requested by a judge or court order, we must provide the requested records. 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 is valid until revoked in writing. The requestor should not **re-disclose** my medical records to another party without further written consent (FS 456.057(12)).

I will not hold Dr. Douglas J. Mason liable for any injury or harm, whether mental, physical, financial, legal, or medical as a direct or indirect result of assessment, evaluation, or treatment.

Place your initials by each specific item to be disclosed.

____ **Neuropsychological Evaluation Report** (may include mental health, substance abuse, (e.g. drugs/alcohol) and or HIV/AIDS status information, diagnostic and treatment records)

____ **Mental Health** ____ **Drug and/or Alcohol** ____ **Psychotherapy Notes**

____ **Treatment Summary** ____ **HIV Testing/AIDS Information** ____ **Medical Psychological Clearance**

____ **Other** _____

Patient or Responsible Party Signature

Date

History Form

Patient Name: _____ **DOB:** _____ **Salutation:** Mr./ Mrs./ Ms./ Miss.

SEX: Male/Female **Handedness:** Right/Left **Highest Level of Education:** _____ **Race:** _____

Current/Past Occupation (s): _____

Social History: ___ Married ___ Single ___ Divorced ___ Widowed ___ Living w/Significant Other Name _____

Do you have a Power of Attorney ___ Yes ___ No (Must Provide) **Children:** ___ Yes ___ No **Names** _____

Sexual History: Are you sexually active: ___ Yes ___ No Sexual Partners past year: ___ # men ___ # women ___ Any STD's _____

How Much Alcohol do you Consume Daily/Type _____ **Is there a History of Substance Abuse** _____

Presenting Problem(s) _____

Medications: Please list all medications or herbal supplements you take and their dosage:

<u>Drug:</u>	<u>Dosage:</u>	<u>Drug:</u>	<u>Dosage:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies / Reactions: _____

Names of current doctors:

<u>Doctor</u>	<u>Phone Number:</u>	<u>Doctor:</u>	<u>Phone Number:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Psychiatric / Psychological Diagnoses and Year: _____

Have you ever Attempted Suicide, if yes explain: _____

List any Current/Past Medical Conditions and Year: _____

List any Neurological/History and Year: _____

Operations: List names and dates of all operations:

<u>Year</u>	<u>Name of Operation</u>	<u>Type of Anesthesia</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you or any blood relative had:	Yes	No	Who	Year
Substance use/abuse	_____	_____	_____	_____
Alzheimer's/Dementia	_____	_____	_____	_____
Depression/Anxiety	_____	_____	_____	_____
Epilepsy or seizures	_____	_____	_____	_____
Parkinson's	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Head Injury (Self)	_____	_____	_____	_____
Toxic Exposure (Self)	_____	_____	_____	_____
Other Conditions	_____	_____	_____	_____

List Test Done in the Past Year and Place Done Imaging (MRI, CT, PET), EEG, Neuropsychological Testing.

The above information may be disclosed in accordance with the HIPAA Privacy Act.

Signature _____

Date: _____