Informed Consent

Southern Oregon Neuropsychological Clinic

Patient Name:____
First Middle Last

Address:____
(street or P.O. Box Number)

____
(city, state, zip code)

Date of birth:_____________________________Known Allergies:________________________________

Gender:____________ Marital Status:_____________ Referred by:_____________________________

Statement goes to (Parent/Guardian):____

at (mailing address if not as above)____

Do you have insurance? Y/N If yes circle one: Medicare/Commercial/Medicaid

Home Phone:_____________________________ Work/Message Phone:______________________________

Emergency Contact:______________________________ Phone:__________________________________

May we leave messages for you at home? Yes or No At work? Yes or No

I understand and agree that I, rather than my insurance carrier, am ultimately responsible for paying fees charged for services provided by this office. If an insurance claim is filed, I authorize the release of any psychological or medical information to the insurance company necessary to process the claim and I direct my insurance company to pay
by check made out and mailed to S.O.N.C., 837 Alder Creek Road, Medford, OR 97504. I have read the cover letter and understand this office's financial policies. If I am unable to keep an appointment, I will give at least 24 hours' notice to avoid a charge.

I understand that there are limits to confidentiality. S.O.N.C. is a clinic with multiple providers. Your record will be available for review by any of our providers when deemed necessary. If there is evidence that I am a danger to myself or others, information may not be held confidential. This includes incidents of child or elder abuse. This office will always provide reports to attorneys, or the courts, that are subpoenaed, regardless of findings.

I understand that S.O.N.C is not a mental health treatment clinic and does not offer crisis counseling and management. I understand that I will be directed to 911 or the local emergency room if I contact S.O.N.C requesting crisis counseling and management.

A copy of our Privacy Practices is available upon request and is displayed in the waiting room.

DATE:________________________SIGNED:____

Clinical Information Sheet
Southern Oregon Neuropsychological Clinic

1. Please print your full name: ______________________________

2. Age: ______________________________ 3. Right or left-handed (circle one)

4. Education (circle one):

Less than High School (grade completed) ______________________ High School

Some College (years)______________________ College Graduate Graduate School

5. Are you (circle one): **MARRIED/SINGLE/DIVORCED/WIDOWED**

6. Do you have any children? (circle one) YES/NO How many? ______________________

How old are they? ______________________________

7. How many people are currently living in your household? ______________________

Also, how are they related to you? (e.g., son/daughter, parent, spouse)

____

8. What are your symptoms/concerns? When did your symptoms begin?

____

____

____

____

____

9. Are you driving? (circle one) **YES/NO**

If yes, are you having any problems with driving? Please describe:

____

PLEASE TURN OVER
CONTINUED ON OTHER SIDE

Clinical Information Sheet

10. Have you ever been treated for a psychological condition such as depression or anxiety with counseling and/or medication? **YES/NO**

If so, what year were you first treated? ______________________ Are you currently receiving treatment? **YES/NO**

11. Do you use drugs or alcohol? **YES/NO** Do you have a history of drug or alcohol abuse? **YES/NO**

If so, when did you start? ____________________________

When was the last time you used?____

12. Are you currently working? **YES/NO** If yes, what type of work?

____

Sign: ____ Date: ___________________________

Medication list – Please include all prescription and over the counter medications/supplements

Name:

Date completed:

Name	Dosage	When do you take it and how often?