Neurobehavioral Consultants
Clinical Neuropsychology & Psychological Evaluations

Paris Office
3737 Lamar Ave. Suite 100
Paris, TX 75460
(P): 903.609.6373
Fax: 972-534-2014

DFW Office
303 TX-78 Suite 100
Sachse, TX 75098
(P): 214-762-1150
Fax: 972-534-2014

PRACTICE POLICY ACKNOWLEDGMENT FORM

Welcome to our practice!

Please sign below to indicate that you have carefully read and accept all of the information provided in this packet. If you have any questions or have difficulty reading or understanding what this information is stating, we are more than happy to verbally review all of this information with you. This document contains important information about our professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before I provide you or your child psychological services. We can discuss any questions you have about the procedures at any time. You are entitled to ask for further clarification of any of the information below or other questions that you may have throughout your treatment and/or evaluation.

When you sign this document, it will represent an agreement between you and Neurobehavioral Consultants, PLLC. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred to us. Neurobehavioral Consultants, PLLC is a professional limited liability company and a group practice. After reading through the attached packet of information in its entirety, please sign below acknowledging that you have read the above information, insurance assignment and release, practice disclosure statements, policies on our fees and use of third party payors (e.g., insurance), informed consent, limits of confidentiality, notice of privacy practices/rights to privacy, and have had the opportunity to discuss the contents with us. By signing below, you are also attesting that you consent to treatment by Levi Armstrong, Psy.D., MSCP and/or his clinical staff (Neurobehavioral Consultants, PLLC) with the knowledge of the above conditions.

____
Patient Name (please print)

____
Patient or Guardian Signature & Date

Insurance Information

Insurance Carrier:______________________ Member ID #_____________ Group #_______________________

Primary Name on Policy:______________________DOB for Primary Policy Holder:______________________

Number on Back of Card to Call for Benefits:____

Patient SS#:_______________How Do You Plan to Pay for Co-Insurance/Deductible?______________________

By signing the first page of this document, you agree to pay your portion of any co-insurance, deductible, co-pays or other charges due to Neurobehavioral Consultants, PLLC and/or Levi Armstrong, Psy.D., MSCP

Assignment and Release

I certify that I, the patient, and/or my dependent have insurance coverage with the above listed insurance carrier and assign directly to Neurobehavioral Consultants, PLLC and/or Levi Armstrong, Psy.D., MSCP all insurance benefits, if any, otherwise payable to me for services rendered. The signature on the first page of this document attests to my understanding that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the administrative and/or clinical staff of Neurobehavioral Consultants, PLLC and/or Levi Armstrong, Psy.D., MSCP to release all information necessary (including diagnoses, mental health records and substance abuse records) to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Authorization for Disclosure & Release of Confidential Information

I authorize Levi Armstrong, Psy.D., MSCP and/or the clinical staff at Neurobehavioral Consultants, PLLC to disclose and receive in both written and verbal communication the confidential medical and psychological records/information concerning the above listed patient to the identified person(s)/agencies to be named below:

Name of Person or Agency ____

Phone and Fax Number:____

Name of Person or Agency ____

Phone and Fax Number:____

Name of Person or Agency ____

Phone and Fax Number:____

Expiration Date:_____________________

I authorize Dr. Levi Armstrong, his staff, and Neurobehavioral Consultants, PLLC to use professional judgment in deciding what specific information will be released and communicated and whether specific records should be disclosed or whether a summary of treatment should be disclosed instead of specific records. I understand that any treatment records concerning my medical treatment are confidential under Texas law (unless ordered by a court of law), and that a statutory privilege prohibits confidential treatment information from being disclosed without my consent. This authorization may be revoked at any time, except to the extent that information has already been released. If not revoked, it shall terminate one year from the date of authorization.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT FOR DISCLOSURE OF INFORMATION IN WRITING AT ANY TIME

Printed Name of Patient: ____________________________________ Date of Birth:_________________

Patient/Guardian Signature & last four numbers of Patient's SS#: ______________________________

Date: ____

New Patient Information Form

Patient Name:_________________________________Date of Birth:_________________ Age:_______

Home Address:____

Legal Guardian Name:___________________________Email Address:___________________________

Home Phone:_______________________Cell:___________________Other:_______________________

Preferred Method of Communication (Circle One): Home Phone Cell Phone Work Phone Email
Who Referred You or the Patient to Us?____________________ Can we leave a voicemail? Yes No

What is the patient's highest education level (or what grade is the minor patient currently in)? _____________

Is the patient right or left handed (circle one): RIGHT LEFT

Did an attorney refer the patient for this exam? YES NO

Is this exam intended to be used in child custody, civil, or criminal litigation? YES NO

Is this exam court ordered or due to a motor vehicle accident? YES NO

Developmental History

Was the Patient Born on time? Yes No Unknown How Many Weeks Early________________

Patient's Weight at Birth: ______________ Normal Pregnancy/delivery?: Yes No Unknown

Please Provide Details / List Any Complications with the Patient's Mother's Pregnancy or Delivery:_________

____

____

____

Did the Patient Experience Any Delays with the Following Developmental Milestones?

Crawling Walking Talking/Speech Fine Motor Skills Social Skills No Delays

Briefly describe the patient's early childhood personality style, social skills, and/or behaviors:______________

____

____

Academic History

What Was the Last Grade the Patient Completed:_________ What Grade is the Patient Currently In:___________

Has the Patient Ever Failed or Repeated a Grade? Yes No If Yes, which grade(s):____________________

Academic Areas of Difficulty in School:____

Academic Areas of Strength in School:____

Grade Average in K-8th (approximate – Circle One): A's B's C's D's F's

Grade Average in High School (Circle One): A's B's C's D's F's N/A

Grade Average in College (Circle One): A's B's C's D's F's N/A

Did the Patient Receive Any of the Following in School or College?

Speech Therapy Special Education Accommodations Occupational Therapy Physical Therapy

Modified TAKS/STAAR Autism Diagnoses Learning Disability Diagnoses ADD/ADHD Diagnoses

Did the Patient Get into Trouble at School Very Often? Yes No

If Yes, for what?____

Briefly Describe the Patient's Social Skills and/or any Behavioral Problems in School:_____________________

____

____

____

____

Medical & Mental Health History

Name(s) of Treating Physicians____

Current **Medical** Conditions:____

____

Current **Mental Health** Conditions:____

____

Please List All **Physical Symptoms** the Patient is Currently Experiencing:______________________

____

____

____

Please List All **Mental Health Symptoms** the Patient is Currently Experiencing:__________________

____

____

____

Please List All **Cognitive (thinking) Symptoms** the Patient is Currently Experiencing:_____________

____

____

____

Surgical History (Purpose and Approximate Date): ______________________________________

____

Any History of the Following (Circle All That Apply):

Traumatic Brain Injury (TBI) Stroke Brain Cancer Seizures Heart Rhythm Problems

Major Hospitalization Major Injuries/Illness Exposure to Toxic Substances Heavy Alcohol/Drug Use

Chronic Pain Liver Disease Kidney Disease Heart Attack Motor or Vocal Tics Tremors

Chemotherapy Radiation Therapy Sleep Apnea COPD Balance Problems/Dizziness Passing Out

Please List ALL Your Current Medications, OTC Medications, and Supplements

Medication Name	Dosage/When Taken	Purpose	Any Side Effects?

Last Medical Check-Up Date & Results:____

Current Height:__________**Current Weight**:__________**Any Drug Allergies?**________________________

Additional Mental Health History

Have You Ever Participated in Counseling? Yes No If Yes, when and where:__________________________

Any Mental Health Hospitalizations or Drug Rehab Hospitalizations? Yes No

Have You Ever Attempted Suicide? Yes No If Yes, When:_______________________________________

How Many Alcoholic Drinks Do You Drink Per Week (Circle One): 0 1-2 3-5 5+ Other_____________

Do You or Have You Ever Used Any Illicit Drugs: Yes No

If Yes, Which Ones, How Much, and How Often?____

Do You Feel That You Are Addicted to Any Medications or Substances? Yes No

Do You Smoke Cigarettes/Cigars? Yes No If Yes, How Many Per Day:_________________________

Do You Use Tobacco in Any Other Form? Yes No Please Describe:____________________________

Family Medical/Mental Health History

Biological Mother's Medical Conditions/Mental Health Diagnoses:____

____

Biological Father's Medical Conditions/Mental Health Diagnoses:____

____

Other Family Medical Conditions/Mental Health Diagnoses:____

____

____

Any Family History of the Following (Circle All that Apply):

ADD/ADHD Autism Asperger's Intellectual Disability Anxiety Depression Bipolar

OCD Schizophrenia Learning Disabilities Speech Problems Seizure Disorder Brain Cancer

Stroke Dementia Multiple Sclerosis Huntington's disease Parkinson's disease Substance Abuse

Work History (if applicable)

Current Employer & Job Title (Include Start Date):____

Past 3 Employers & Job Titles (Include Dates & Reasons for Leaving):____________________________

____

____

Military/Armed Forces History & Dates of Deployment:____

If you are currently unemployed, what prevents you from working? (if you are disabled, please provide details about how this disability affects your ability to work):____

____

____

____

____

Social History

Is the patient currently married? Yes No Spouse's Name:______________________________

Does the patient have any children? Yes No If so, how many and what are their ages?__________

How many times has the patient been married?______________________________

<u>If the patient is a child,</u> how well does he/she get along with their peers?______________________________

____

____

Activities of Daily Living (only circle those that are age-expected)

Does the patient have any current difficulty with completing the following (circle all that apply):

Communicating With Others Dressing Bathing Personal Hygiene Walking

Fine Motor Skills Balance Managing Medication Managing Finances Driving

Reading Spelling Basic Math Skills Social Skills/Social Judgment Using a Phone

Legal History

Are You, the Patient, or Your Family Currently Involved in **<u>ANY</u>** Civil or Criminal Litigation? Yes No

If Yes, Describe Briefly:______________________________

Are You, the Patient, or Your Family Involved in **<u>ANY</u>** Child Custody or Divorce Proceedings? Yes No

Is the Patient Currently On Workman's Comp? Yes No Reason:______________________________

Is the Patient Currently Applying for Social Security Disability (SSDI) Yes No

Name and Contact Information for Attorney(s):______________________________

Has the Patient Ever Been Arrested or Incarcerated? Yes No If Yes, When and For What?__________

____

____