Date: _____

NEUROPSYCHOLOGICAL HISTORY QUESTIONNAIRE*

Confidential

Identifying Information/ Reason for Referral

Patient's Name: _____ DOB: _____

Age:_____ Yrs Ed:_____ Occupation: _____ Last Period Employed:_____ Sex/ Gender: ☐M ☐F

Queer ☐ Non-Conforming/ Non-Binary ☐ Transgender Female (M to F) ☐Transgender Male (F to M) ☐Prefer not to answer

Marital Status: ☐Never Married ☐ Married: #Times___ # Years___ ☐ Separated ☐ Divorced ☐ Widowed

Years married to current spouse _____ His/Her health: ☐excellent ☐ good ☐ poor

Handedness: ☐R ☐ L ☐ Ambidextrous Primary Language: ☐Arabic ☐ English ☐French ☐ Spanish ☐ Other

☐ 2nd language_____ ☐ 3rd language_____ ☐ 4th language_____

Ethnicity: ☐Arab ☐Afr. Amer./Black ☐Asian ☐European/Caucasian ☐Hispanic ☐Indigenous Amer. ☐Other:

Referring Person: _____ Facility/Address: _____Phone: _____

Person Completing This Form: ☐Self ☐Other _____ Relationship to Patient: _____

[Collateral Interview Source: _____ Relationship to Patient: _____ Day Phone:_____]

What is your understanding of why you are undergoing this evaluation? Include all pertinent facts, such as date of injury/illness, what happened, etc.:

_____

_____

Have you had neuropsychological testing before? ☐ Yes ☐ No Year: _____

Is this case in litigation or do you intend to pursue litigation in the future? ☐ Yes* ☐ No

_____

* If you are here for an independent medical evaluation (IME) that has been scheduled by your attending physician, attorney, insurance company, or other provider, then the purpose of this evaluation is to obtain an objective opinion on your present condition and to answer specific questions related to your condition that were outlined by the requesting party. Your evaluation will be conducted by an impartial, independent medical consultant who is **not** employed by or affiliated with the party requesting your evaluation. Please be advised that in accordance with their professional ethical standards, psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. The psychologist performing this evaluation should not be viewed as your personal advocate. Limitations to the level of confidentiality and/or professional privilege traditionally afforded may also apply. Results of this evaluation will not be discussed with you, and you will not be provided directly with the consultant's findings, diagnostic opinions, or therapeutic recommendations barring an order of the court. The evaluation results will be summarized in the form of a written report, which will be forwarded to the party that requested this evaluation. Any questions regarding the findings of the evaluation or the report should be directed to the referring party in the usual and customary manner. Should a court of law order the release information obtained during this evaluation, the evaluator may be bound by law to comply with the order.

To the best of your knowledge, please describe your current disabilities, medical problems, or difficulties (i.e., 2009 stroke) and whether your problems have worsened over time:

Please list any current sources of stress in your life (for example, any losses, major changes of circumstances, financial/interpersonal/job pressures, etc.):

Please mark any and all of the following that may be used to describe the characteristics, progression, and/or comorbidities associated with your injury or illness:

☐ Sudden onset ☐Rapid Progression ☐ Slow/Insidious Progression ☐ Initial changes to speech or personality

☐Urinary Incontinence Fecal Incontinence ☐Poor Gait/Walking ☐ Hallucinations/Delusions

Please describe where you received your initial treatment and what services were provided to you (i.e., emergency room and inpatient brain surgery to remove tumor; inpatient rehabilitation therapy; counseling)**:**

Please describe what symptoms or problems are of most concern to you at this time:

Current Symptom Checklist

Please check each of the following symptoms or problems that you are experiencing. Briefly describe each symptom checked (for example, intensity, how long it has been experienced, and how frequent it is):

Cognition/Thinking Abilities — How long have you had this symptom?

- ☐ Problems with being easily distracted
- ☐ Poor concentration for extended periods of time
- ☐ Forgetting conversations and people's names
- ☐ Forgetting recent events
- ☐ Episodes of confusion
- ☐ Getting lost
- ☐ Other memory problems
- ☐ Word finding problems
- ☐ Difficulty pronouncing words clearly
- ☐ Changes in ability to reading or write
- ☐ Difficulty with depth perception/judging distances
- ☐ Difficulty thinking clearly and efficiently
- ☐ Difficulty planning and organizing things
- ☐ Problems with procrastination
- ☐ Difficulty following through or finishing things

Sensory/Motor

- ☐ Vision problems
- ☐ Hearing problems
- ☐ Changes in smell or taste
- ☐ Loss of feeling, tingling, or numbness
- ☐ Difficulty telling right from left
- ☐ Getting tired easily (fatigue)
- ☐ Sensitivity to noise
- ☐ Sensitivity to light
- ☐ Pain
- ☐ Headaches
- ☐ Tremors or shakiness
- ☐ Dizziness
- ☐ Paralysis or weakness in any part of body
- ☐ Balance or coordination problems
- ☐ Changes in ability to walk
- ☐ Falls
- ☐ Hallucinations
- ☐ Black-out spells or Fainting spells

Emotional/Behavioral — How long have you had this symptom?

- ☐ Sleep disturbance; change in sleep pattern
- ☐ Depressed mood
- ☐ Lack of interest in things previously enjoyed
- ☐ Lack of initiative, don't start things up
- ☐ Changes in appetite
- ☐ Changes in sex drive
- ☐ Loneliness
- ☐ Loss of confidence
- ☐ Feelings of guilt
- ☐ Anxiety/excessive worry
- ☐ Panic Attacks
- ☐ Personality changes

Continued on next page…

Emotional/Behavioral

How long have you had this symptom?

- ☐ Irritability
- ☐ Restlessness
- ☐ Getting bored easily
- ☐ Temper outbursts
- ☐ Mood swings, quick emotional shifts
- ☐ Troubling thoughts that are difficult to keep out of mind
- ☐ Nightmares
- ☐ Increased suspiciousness of others

Functional Abilities

How long have you had this symptom?

- ☐ Problems getting dressed
- ☐ Problems bathing or showering
- ☐ Problems remembering medications
- ☐ Problems preparing/cooking meals
- ☐ Problems cleaning
- ☐ Problems driving
- ☐ Problems managing checkbook/finances
- ☐ Problems forgetting meetings/appointments
- ☐ Problems shopping

Other Problems Not Listed Above

- ☐ Other:

Have you had any of the following neurologic problems?	**Treatment/Outcome**
☐ Head injury with loss of consciousness?	
☐ Head injury in which you were "dazed" or confused?	
☐ Loss or change in sense of smell/taste	
☐ Loss of sensation in any part of body	
☐ Paralysis or weakness in any part of body	
☐ Loss of hearing/vision	
☐ Stroke, brain hemorrhage, or TIA	
☐ Meningitis, encephalitis, brain infection	
☐ Brain tumor	
☐ Fainting or dizzy spells	
☐ Heart Attack/Cardiac Arrest/Loss of oxygen	
☐ Drug or alcohol overdose	
☐ Exposure to toxic substances/electric shock	
☐ Syphilis or other sexually transmitted disease	
☐ Severe or persistent headache or migraine	
☐ Parkinson's disease, tremor, movement disorder	
☐ Alzheimer's disease or other dementia	
☐ Multiple sclerosis	
☐ Seizure/ Epilepsy	

Do you currently have epilepsy or a seizure disorder? ☐ Yes, Type: _____ ☐ No

Please describe what happens when you have a seizure:

Please identify any diagnostic tests that you have recently had and describe the results below

☐**Neurological Office Exam** ☐**MRI/ MRA** ☐**CT** ☐ **EEG** ☐ **PET Scan** ☐ **X-Rays**
☐**Ultrasound** ☐**Angiography** ☐ **ECG** ☐ **Lumbar Puncture/ Spinal Tap**
☐ **Swallow Studies** ☐**GI Review** ☐ **Urinalysis** ☐ **Cultures**
☐ **Multi-Chem Profile** ☐ **Bone Density**

Personal Medical History

Please list all illnesses, surgeries, and hospitalizations that you have experienced:

Illness/ Condition	Dates	Treatment

Current Medications

_____

_____

_____

Please list any known allergies: _____

Familial Medical History

Please list all of members of your family of origin (that is, your parents & siblings)**:**

Name	Age	Relationship to you	Current health or Cause of Death	How is your relationship with him/her?
Mother				
Father				
Sisters (How Many? _____)				
Brothers (How Many? _____)				

If applicable, please list your children and describe their health conditions:

Name	Age	Relationship to you	Current health or Cause of Death	How is your relationship with him/her?

Please indicate if anyone <u>biologically related to you</u> has had the following conditions by checking the box and putting their relationship to you in the space provided:

☐ Diabetes		☐ Multiple Sclerosis	
☐ Hypertension		☐ Parkinson's/Huntingtons	
☐ Heart Disease		☐ Alzheimer's	
☐ Stroke		☐ Alcoholism	
☐ Cancer/Brain Tumor		☐ Depression	
☐ Epilepsy		☐ Schizophrenia	
☐ Intellectual Disability		☐ Anxiety	
☐ Learning Disability		☐ ADHD	
☐ Muscular Dystrophy		☐ Bipolar	
		☐ Other	

Personal and Familial Psychiatric History

Have you ever received psychiatric care or been diagnosed with a mental health condition? ☐ Yes ☐ No

Please mark all psychiatric conditions that you currently have or have ever been diagnosed with:

☐ Depression	☐ Bipolar (Manic-Depression)	☐ Anxiety	☐ Eating Disorder
☐ Schizophrenia	☐ PTSD	☐ OCD	☐ Other Psychiatric Problems

Is your therapy current or ongoing? ☐ Yes ☐ No How long did you receive care? _____

Did you feel treatment was helpful? ☐ Yes ☐ No Why? _____

Have you ever thought of suicide? ☐ Yes ☐ No If Yes, when was the last time you thought about it? _____

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No How long did you receive care? _____

Clinician or Hospital	Dates	Problem and Treatment

History of Substance Use

Do you now or have you ever regularly used tobacco products? ☐ Yes ☐ No

How much do you smoke per day?

Do you now drink or did you ever regularly drink alcohol products? ☐ Yes ☐ No

If you currently drink, please describe the frequency: ☐ rarely or never ☐ 1 - 2 days per week ☐ 3 - 5 days per week ☐ daily

Please provide the following description of your drinking history:

☐ I used to drink but stopped on (date): _____

If no longer drinking, what is the reason that you stopped?

I started drinking regularly at age: ☐ less than 10 years old ☐ age 16 – 18 ☐ age 19 – 21 ☐ age 10 - 15 ☐ over 21

Preferred type (s) of drinks: _____

Usual number of drinks I have at a time: _____

My last drink was: ☐ less than 24 hrs ago ☐ 24 to 48 hrs ago ☐ over 48 hrs ago

Check all that apply:

☐ I can drink more than most people my age and size before I get drunk.

☐ I sometimes get into trouble (e.g., fights, work/legal problems, conflicts with my family, accidents) after drinking.

☐ I sometimes blackout after drinking.

☐ I have gone through alcohol withdrawal.

In your opinion, is your drinking a problem? ☐ Yes ☐ No ☐ Not Sure

Have others ever told you your drinking is a problem? ☐ Yes ☐ No

Do you now use or have you ever regularly used illicit or "street" drugs? ☐ Yes ☐ No If Yes, mark which:

☐ Marijuana ☐ Cocaine/Crack ☐ Heroin ☐ Hallucinogens ☐ Ecstasy

☐ Inhalants ☐ Prescription Drug Misuse ☐ Other:_____

Have you ever been treated for alcohol or drug abuse? ☐ Yes ☐ No

If Yes, please describe: _____

Educational, Developmental, and Social History

Where were you born?

_____

Did your mother ever smoke, take drugs, or use alcohol during pregnancy? ☐ Yes ☐ No

You were born: ☐ On Time ☐ Prematurely ☐ Late ☐ Underweight

Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen/special equipment, convulsions, illnesses, etc.)? ☐ Yes ☐ No

If yes, please describe:

Were you ever tested for developmental disabilities or suspected to have developmental problems (e.g., cerebral palsy, specific learning disabilities, autism, etc.)? ☐ Yes ☐ No

If yes, please describe:

Please check each of the following conditions that describe behaviors or emotions that you experienced *as a child*. Use the space next to each items to provide any additional information.

☐ Delay learning to walk		☐ Acted young for age	
☐ Delay learning to talk		☐ Frustrated easily	
☐ Delay learning to read		☐ Excitable	
☐ Behavioral problems at home		☐ Stubborn	
☐ Behavioral problems at school		☐ Poor coordination	
☐ Bedwetting		☐ Hyperactive	
☐ Nail-biting		☐ Blank or staring spells	
☐ Difficulty paying attention		☐ Difficulty making friends	
☐ Memory problems		☐ Impulsivity	
☐ Depressed		☐ Disorganized	
☐ Aggressive		☐ Difficulty controlling emotions	
☐ Shy		☐ Daydream often	
☐ Tantrums		☐ Easily distracted	
☐ Nightmares		☐ Trouble sitting still	
☐ Poor self-esteem		☐ Difficulty finishing projects	
☐ Unpredictable		☐ Attention wanders	
☐ Cried easily and often		☐ Fidgety	
☐ Speech or language problems		☐ Alcohol/drug use	

☐ Other Childhood Problems (please list below)

_____

Please summarize your educational history below (start with your highest level of education):

School Attended	Location	Dates	Grades or Degree Completed	Course of Study	Grade Average

Did you have difficulty with any school subjects? ☐ Yes ☐ No If Yes, list which ones:_____

Did you ever have any special tutoring or counseling? ☐ Yes ☐ No If Yes, explain:_____

Did you ever repeat any grades? ☐ Yes ☐ No If Yes, list which ones:_____

Were you ever placed in special classes in school? ☐ Yes ☐ No If Yes, explain:_____

Were you ever diagnosed with a Learning Disorder? ☐ Yes ☐ No If Yes, explain:_____

Were you ever diagnosed with ADHD? ☐ Yes ☐ No If Yes, at what age:_____

If you were diagnosed with ADHD, were you prescribed medications? ☐ Yes ☐ No Which?_____

If you have ever taken standardized tests such as SAT, ACT, MCAT, or GRE, please list these below:

Test	Date	Scores

Your current occupational status:

☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Disability ☐ Volunteer

If currently employed, please list your job title and describe the type of work you do, including your responsibilities and the nature of the work. Be as explicit as possible:

Please summarize your occupational history below:

Position Title	Place	Dates	Reason for Leaving

Have you ever been on unemployment, disability, or workman's compensation? ☐ Yes ☐ No

If Yes, list the date(s) and reason(s):

Have you had any arrests or legal problems? ☐ Yes ☐ No

If Yes, list dates and nature of the legal issues:

Have you been in the military? ☐ **Yes** ☐ **No**

If Yes, please give branch, service dates, discharge type, rank/ duties, combat history, and disability rating (if any):

Were you ever exposed to dangerous substances on a job (e.g., mercury, radiation, chemicals, etc.)? ☐ Yes ☐ No

If Yes, please explain

Describe any hobbies or other leisure-time activities in which you engaged prior to the accident/ injury:

Describe any hobbies or other leisure-time activities in which you currently engage:

Do you live alone? ☐ Yes ☐ No **Do you own a firearm?** ☐ Yes ☐ No **Do you drive?** ☐ Yes ☐ No

Current living arrangement: ☐ House ☐ Condo ☐ Apt ☐ Asst. Living ☐ Skilled Nursing ☐ Hospice
☐ Stairs ☐ Elevators ☐ Asst. Devices ☐ Safety Devices

Describe architectural barriers, if any (ie. can't walk up stairs, can't use shower or bathtub)**:**

Please provide any additional information regarding your residential status and needs (i.e., reduced ability to care for self independently,; becomes lost inside/outside of home)**:**

Please describe the level of assistance required to complete the following activities of daily living, if any:
(Key: Ind= Independent; Min = Minimal Support; Mod = Moderate Support; Max = Maximum Support)

ADLs	Ind	Min	Mod	Max
Bathing/showering	☐	☐	☐	☐
Getting dressed	☐	☐	☐	☐
Taking medication	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transfers	☐	☐	☐	☐
Incontinence	☐	☐	☐	☐
Feeding	☐	☐	☐	☐
Other:	☐	☐	☐	☐

IADLs	Ind	Min	Mod	Max
Using the telephone	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Meal Preparation	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐
Laundry	☐	☐	☐	☐
Driving/Transportation	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐
Financial Management	☐	☐	☐	☐

Do you currently have a personal assistant, home nurse, or other caregiver: ☐ Yes ☐ No
If yes, describe the amount of help received each week: _____hours _____days

Please add any additional information that you feel may be useful:

COVID-19 QUESTIONNAIRE

Have you had or ever been diagnosed with COVID-19? ☐ Yes ☐ No

If no, stop here……

If yes, when were you diagnosed? _____

Did you experience symptoms? ☐ Yes ☐ No

What was the first symptom? _____What was the most severe symptom? _____

If you were asymptomatic, how did you find out you had COVID-19?

☐ Family/friend was diagnosed ☐ Routine screening ☐ Other (please explain):_____

Were you hospitalized for your symptoms? ☐ Yes ☐ No For how long? _____

Were you admitted to the Intensive Care Unit (ICU)? ☐ Yes ☐ No

How long? _____Were you put on a ventilator? If yes, how long? _____Oxygen (O_2) levels?_____

Have you experienced other medical complications as a result of COVID-19? ☐ Yes ☐ No If yes, please explain:

_____

Have you experienced brain fog since testing positive for COVID? ☐ Yes ☐ No If yes, please explain:

_____

Since recovering from COVID-19, do you continue to experience any symptoms? ☐ Yes ☐ No

If yes, please explain:

Please **check** each of the following symptoms or problems that you experienced. For each symptom you check, please briefly describe how long you have experienced it and how severe it was:

Physical	Before Covid	During COVID	Post COVID	Describe Symptoms	How long?
Loss of sense of smell or taste (anosmia)	☐	☐	☐		
Fever	☐	☐	☐		
Pneumonia	☐	☐	☐		
Dry cough	☐	☐	☐		
Shortness of breath (dyspnea)	☐	☐	☐		
Hypoxia or hypoxemia	☐	☐	☐		
Respiratory failure	☐	☐	☐		
Sepsis/Septic shock	☐	☐	☐		
Organ dysfunction/failure	☐	☐	☐		
Acute respiratory distress syndrome (ARDS)	☐	☐	☐		
Stroke or Transient ischemic attack (TIA)	☐	☐	☐		
Other:	☐	☐	☐		
Psychiatric/psychological	☐	☐	☐		
Altered mental status/ Delirium	☐	☐	☐		
Confusion	☐	☐	☐		
Irritability	☐	☐	☐		
Depression	☐	☐	☐		
Anxiety/excessive worry	☐	☐	☐		
Sleep Problems	☐	☐	☐		
Nightmares	☐	☐	☐		
Flashbacks	☐	☐	☐		
Panic attacks	☐	☐	☐		
Cognitive	☐	☐	☐		
Attention/concentration problems	☐	☐	☐		
Memory problems	☐	☐	☐		
Slowed thinking speed	☐	☐	☐		

Clear Cognition, PLLC

☐ Barrington ☐ Libertyville ☐ Rolling Meadows

PATIENT INFORMATION

Last Name_____ First_____MI_____Marital Status_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Date of Birth_____Age_____Sex_____Soc Sec Num_____

Email Address_____ Referred By_____

Employer_____Work Phone_____

GUARANTOR INFORMATION

WHOMEVER BRINGS IN MINOR CHILD MUST COMPLETE THIS SECTION

Last Name_____ First_____MI_____Marital Status_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Date of Birth_____Age_____Sex_____Soc Sec Num_____

Email Address_____

POLICYHOLDER INFORMATION

Last Name_____ First_____MI_____Marital Status_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Date of Birth_____Age_____Sex_____Soc Sec Num_____

	PRIMARY	SECONDARY	OTHER
INS COMPANY NAME			
POLICY HOLDER NAME			
POLICY NUMBER			
RELATIONSHIP TO PATIENT			

All signatures contained herein apply to services rendered at: *Clear Cognition, PLLC*

Informed Consent for Treatment:

I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature SIGN HERE **Date**_____

Relationship to patient (if applicable)_____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient Name_____ **Date**_____

Patient Signature SIGN HERE

Medicare Authorization and Assignment of Benefits:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature SIGN HERE Date_____

HIPAA Privacy Notice Acknowledgement:

I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

Signature SIGN HERE **Date**_____

1800 Hollister Drive, Suite G10 Libertyville, IL 60048
Phone: 847.786.5366 Office Fax: 847.786.5535 Referral Fax: 949.862.8661

Consent for Psychological/Neuropsychological Evaluation

I understand that the purpose of this evaluation is to provide information about me for my physician or other health care provider who has requested the evaluation in order to assist in their diagnosis and treatment of me. The material from the interview(s) and psychological/neuropsychological testing will result in the generation of a report that will provide information related to my diagnosis and treatment. With my written authorization, the report generated by my Clear Cognition neuropsychologist will be sent to my physician or other health care provider, and the neuropsychologist will also discuss the results of the evaluation with them. If desired by me or my referring provider, my Clear Cognition neuropsychologist will also discuss the results with me and any others which I so designate by signing a release of information allowing them to do so. If this evaluation is being covered or partially covered by my insurance, Neurobehavioral Associates may be required to provide the insurance company with a report as well.

Questions posed by my Clear Cognition neuropsychologist will touch on personal matters that could cause me emotional discomfort and revive painful memories. I recognize that my Clear Cognition neuropsychologist has no intention of causing any personal discomfort to me, but that they are simply carrying out a professional task associated with this evaluation. Even though some of the subjects under discussion may not appear at first glance to have a direct connection with this issue at hand, I will cooperate to the best of my ability. I understand that although I am expected to give honest and accurate answers, I am free to refuse to answer any question I choose or to terminate the evaluation whenever I wish.

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 signed Release of Information.

• 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.

• 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:

o The client threatens suicide.

o The client threatens harm to another person(s), including murder, assault, or other physical harm.

o The client reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.

o The client reports abuse of the elderly.

State law mandates that mental health professionals may need to report the above 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 Neurobehavioral Associates and the client will otherwise be deemed confidential as stated under Illinois state law.

Financial Agreement

Your insurance company will only pay for services that it determines to be "reasonable and necessary" under your insurance plan. If they determine that a particular service, although it would otherwise be covered, is not reasonable and necessary under their standards, they are likely to deny payment for that service. Thus, in some circumstances, your insurance policy may deny at least a portion, or perhaps all, of the claim. In this instance the responsible party will be responsible for the full payment.

Should you receive a bill for services, payment is due within six weeks of the billing date. A monthly late fee of $5 will be assessed for payments received after the due date. In the event this account is turned over for collection, the responsible party, as noted below, agrees to pay all costs of collection including but not limited to court costs, collection costs and attorney fees.

Note: Neuropsychological testing includes time for (a) clinical interview, (b) test administration, (c) scoring of the tests, (d) test interpretation, (e) preparing the report, and (f) discussion of the results. In non-forensic/non-medical-legal cases, this will typically add 1-4 hours to the actual testing time. Forensic/medical-legal cases typically require more time including record review and consultation with an attorney. The responsible party as noted below accepts responsibility for these charges.

Having read and understood the above, I agree to the terms of this evaluation.

Patient Signature_____

Patient Name (please print)_____

Guardian's Signature or Responsible Party (if applicable)_____

Guardian's Relationship to Patient_____

Guardian's Phone Number_____

Guardian's Address (Street, City & State)_____

Date: _____

OFFICE USE ONLY
An attempt was made to obtain the patients signature that he/she received the HIPAA Notice Form but I was unable to obtain the patient's acknowledgement by signature. Reasons for failure to obtain patients acknowledgement by signature:
____Physical Impairment ____Patient refused to sign ____Other:_____

1800 Hollister Drive, Suite G10 Libertyville, IL 60048
Phone: 847.786.5366 Office Fax: 847.786.5535 Referral Fax: 949.862.8661

Consent Form for Email Contact

Recipient of Service: _____

DOB: _____

I hereby confirm that the service providers of Clear Cognition can use the email address provided below as a method of communication with me.

Email address (please print):_____

I understand that Clear Cognition will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect privacy when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- email can be forwarded, printed and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement;
- email may be sent to the wrong address by any sender or receiver;
- email is easier to forge than handwritten or signed papers;
- copies of email may exist even after the sender or the receiver has deleted his or her copy;
- email service providers have a right to archive and inspect emails sent through their systems;
- email may be intercepted during transmission without detection or authorization;
- email is not a secure way of corresponding and i have been advised not to transfer any sensitive information in this format; and
- email can spread computer viruses.

I understand that I may withdraw this consent at any time.

Patient's signature _____ Date _____

Legal guardian's printed name and signature (if applicable) _____

I, the undersigned, witnessed, the signature(s) above and can attest to the identity of the consenting person:

_____ Witness

1800 Hollister Drive, Suite G10 Libertyville, IL 60048
Phone: 847.786.5366 Office Fax: 847.786.5535 Referral Fax: 949.862.8661

Authorization to Release Health Information

Client Name: _____ Birth Date: ____/____/____

Previous Name(s): _____ SS#:XXX-XX-____

As the above named client, I authorize Clear Cognition to: X obtain X release
(Name of Client or Legal Guardian)

O psychological / psychiatric records
O school records
X evaluation and treatment records
O psychological evaluation
X neuropsychological evaluation
X neuropsychological data summary sheet

X other: Any & All As Requested

from/to_____
(Name of Facility/Clinician)

_____ Phone: _____ Fax: _____
(Address of Facility/Clinician) (Phone # of Facility/Clinician)

for the purpose of Continuity of Care

I understand that I have the right to inspect and copy all information to be disclosed, except to the extent not allowed by the Illinois Mental Health Code. I understand that I may revoke this authorization at any time except to the extent that action has been taken on this authorization. I further understand that this authorization shall expire without my express revocation on:_____. I understand that Clear Cognition will make reasonable efforts to ensure that information delivered via fax has been sent securely to the intended receipt but am aware that there is still a privacy risk when records are transmitted via fax. I further understand that the agency or individual which receives this information, in accordance with State/Federal laws, should not disclose information without further consent. Clear Cognition cannot guarantee that agencies or individuals receiving this information will act in compliance with these laws. Without duly authorized consent no records can be released.

_____ _____
(Signature of client) (Date)

_____ _____ _____
(Signature of authorized legal guardian) (Date) (Relationship, if authorized representative)

_____ _____
(Witness) (Date)

Release of Information to Insurance Plans and Assignment of Payment (Preview)

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and or attorney's fee will be my responsibility to pay.

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the related consumer disclosure. (required)

Please type your name to sign below | Date

/ /

☐ I am the parent/guardian of this patient

/ /

X _____