**AAA Neuropsychology, LLC**
59 General Warren Blvd · Suite 101 · Malvern, PA 19355
Phone: **484-870-5608** · Fax: 484-870-5609
Email: info@aaaneuropsych.com · Web: http://aaaneuropsych.com/

Thank you for taking the time to read over this information. Of course, please feel free to call our office (484-870-5608) or email (info@aaaneuropsych.com) if you have any further questions, we would be happy to help!

## Things to bring to your neuropsychology appointment

- ☐ Photo identification (e.g. driver's license)
- ☐ Primary and secondary insurance cards (if applicable)
- ☐ Lunch or snack. We have a refrigerator for storage if you need it.
- ☐ Hearing aids or reading glasses, if applicable
- ☐ Any routine medications you need for the day can be taken.
    - If this is an ADD/ADHD evaluation, we prefer that you NOT take your ADD/ADHD medication on the day of the evaluation since it can affect cognitive test performance, but please check with your doctor first.

Please try to get a good night's rest the night before the evaluation.

Please avoid alcohol and illicit drugs at least 24 hours prior to the evaluation.

****PLEASE SUBMIT YOUR COMPLETED FORMS TO INFO@AAANEUROPSYCH.COM BEFORE YOUR APPOINTMENT****

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# Client Information Form

## A. Identification:

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Cell: _____Home: _____E-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Please list any family members/loved ones that you authorize us to communicate with here: _____
_____

## B. Referral: Who gave you our contact information?

Name: _____ Phone: _____Address: _____

May we thank this person for the referral? ❑ Yes ❑ No

How did this person explain how we might be of help to you? _____

## C. Providers: Please list relevant current treatment providers below

| | Provider Name | Practice Affiliation | Address | Phone Number | Please check if we can contact for information or records | Please check to release your report to this provider |
|---|---|---|---|---|---|---|
| **Primary Care Physician:** | | | | | | |
| **Neurologist:** | | | | | | |
| **Psychiatrist:** | | | | | | |
| **Psychologist/ Therapist:** | | | | | | |
| **Other:** | | | | | | |

**D. Payment information:** Is this evaluation for treatment planning purposes only? ❑ Yes ❑ No ❑ Not Sure

Please check if you are currently involved or plan to be involved in any of the following situations:

| | No | Yes, please briefly explain |
|---|---|---|
| Personal injury law suit/litigation | | |
| Worker's compensation claim | | |
| Disability application or appeal | | |
| Fitness for duty evaluation | | |
| School IEP/special education assessment | | |
| Other legal involvement | | |

**Primary Insurance**

Health insurance carrier/company name: _____ Policy #: _____

Name of policyholder (if not the patient): _____Policyholder's date of birth: _____

Policyholder's SSN:_____Relationship to patient: _____

Policyholder's address: _____ Phone # of provider services (back of card):

_____

If you have a copay, please indicate amount $ _____ and method of payment _____

**Secondary Insurance**

Health insurance carrier/company name: _____

Name of policyholder (if not the patient): _____Policy#: _____

If you do not have insurance, how will you pay for services from this office? _____

**E. Signature:** I attest that the above information is accurate to the best of my knowledge.

Name (printed): _____ Witness:_____

Signature: _____ Date:_____

***(Signature required by patient if 14 years old or older)***

Signature of Authorized Person (if applicable): _____Relationship: _____

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# Informed Consent for Clinical Neuropsychological/Psychological Evaluation

**Purpose:** You have been referred for a clinical neuropsychological/psychological evaluation. If we are billing your insurance company, this is considered a clinical evaluation for treatment planning purposes only. This type of evaluation is not intended to be used for legal/forensic or school purposes. If you plan to use the evaluation for other purposes (e.g., law suits, disability application, work or fitness for duty, school IEP, worker's compensation law suit), you should notify us ahead of time so that we can conduct an appropriate evaluation for you.

**Examiner:** You will be working primarily with licensed psychologists (or neuropsychologists) and their designees for this exam. The clinical interview and feedback sessions will be with the doctor; however, a trained psychological assistant may administer some or all the standardized tests under the direct supervision of the psychologist/neuropsychologist.

**Nature of Evaluation:** neuropsychological/psychological examination begins with a clinical interview, where questions will be asked about your background and current symptoms/concerns. This is meant to understand you and your experiences better. Most of what you share will be included in a detailed clinical report that will be released to the referral source and others you authorize. Standardized psychological or neuropsychological paper-pencil and computer tests may then be administered to you. These tests measure thinking in areas such as intelligence, attention, memory, language, problem-solving, visuospatial skills, etc. Understanding your personality, emotional and sociocultural functioning is also often part of our evaluations. The length of the evaluation depends on your presenting concerns and your pace. After completing the testing, we will schedule a feedback session a few weeks later to review your results and discuss our recommendations. We will then finalize the report and send it to those you have authorized to receive it. Throughout the evaluation, your task is to do your best and answer questions as accurately as you can, so that we can get a true understanding of your strengths and areas of need.

**Foreseeable Risks, Discomforts, and Benefits:** The results of this examination may either support or not support your concerns. For some individuals, evaluations can cause fatigue, frustration, and anxiousness. Our goal is to minimize these factors, so please let us know so we can try to accommodate your needs.

**Limits of Confidentiality:** When we examine, test, diagnose, treat or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information to decide what assessments or treatments are best for you. We may also share this information with others to arrange payment for your evaluation, to carry out certain business or government functions, or to help provide other services for you. Your PHI will also be accessible by individuals associated with the referral source and their representatives. Information obtained during evaluation is confidential and can ordinarily be released only with your permission. There are some times when the laws require us to use or share your information. For example: 1) when there is a serious threat to your or another's health and safety or to the public (including statements indicating harm or abuse of children or vulnerable adults); 2) when we are required to do so by lawsuits and other legal or court proceedings; 3) if a law enforcement official requires us to do so; and 4) for worker's compensation and similar benefit programs. There are also some other rare situations further described in our notice of privacy practices.

In the event that you or someone on your behalf chooses to post online reviews of our practice, please note that you are publicly acknowledging a provider-client relationship and thus have waived your right to privacy. You should be aware of any potential negative impact that could occur based on this disclosure. Furthermore, the nature of the confidential relationship between you and the provider is known to contribute to the effectiveness of psychological work. Instead, we invite clients to share their comments – either positive or negative directly with us. We are always willing to discuss your reactions and will work with you to make your experience a positive one.

**Recordings:** During the testing, we may make video or audio recordings for supervision and quality control purposes. If you would like to decline video/audio recordings for these purposes, please let us know in writing.

**Telehealth:** If any part of the evaluation is being conducted remotely using telehealth technologies such as video or telephone conferencing, while most research shows that telepsychology is as effective as in-person services, there are additional risks of remote evaluation. This includes the potential for other people to overhear the session or technology failures. We will take reasonable steps to ensure your privacy, and you should do the same. We try to minimize technology related risks by using a HIPPA compliant web platform. If the session is interrupted for any reason due to technological failures, please return to the same link to resume the session. If you are having an emergency, do not call us back; instead, call 911, or go to your nearest emergency room. Call us back after you have called or obtained emergency services. Please note that recordings of the remote session through screen capture and video/audio recording is strictly prohibited.

**Financial and Office Policies:** Your clear understanding of our financial and office policies is important to our professional relationship. Please ask if you have any questions about payment for our services, our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any changes (i.e., address, name, insurance, etc.).

- **Co-pays:** All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with us. We currently accept cash, check, or credit card payments.

- **Insurance Claims:** Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in your responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any part of your services performed at our office, you are responsible for the complete balance of the non-payable services. We will send you a bill. If we are out of network with your insurance company and your insurance pays you directly, you are still responsible for payment and agree to forward the payment to us immediately.

- **Workers' Compensation and Automobile Accidents:** In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier/adjuster prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. Again, if the claim is not paid to us, we will send you a bill that you are responsible to pay.

- **Missed Appointments:** We require 2-business day notice of appointment cancellation or rescheduling. Appointments missed without 2-business day notification may be charged a fee of $150.00 for an intake or feedback appointment and $300 for a testing appointment. Our office has a 3 strikes policy for no-shows, after which we may not reschedule your appointment.

- **Outstanding Balance Policy:** It is our office policy that all past due accounts be sent at least 2 statements. If payment is not made on your account, a phone call will be made to try to make payment arrangements. If no resolution can be made, the account may be sent to a collection agency or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

- **Other Fees:** We charge a minimum $25 fee for every page of additional paper-work or clinical letters that we are asked to complete on your behalf beyond the clinical report we will prepare for the referral source. Clinical evaluations also do not include extensive record reviews, so we charge an hourly rate for any records (beyond 15 pages of clinical notes) that we are asked to review. We also charge our standard record retrieval and copying fees for report requests 30 days after completion of our clinical evaluation.

**Consent:**

- I hereby give my consent for AAA Neuropsychology to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).
- With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.
- With this consent, the Practice may email or mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements, evaluation reports, and anything pertaining to my clinical care if they are sent securely.
- I consent to participation in neuropsychological/psychological care.
- I give this office permission to release any information obtained during my care that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.
- I understand that I am ultimately responsible for all payments and charges, regardless of insurance coverage.
- I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the Practice. Medicare regulations may apply.
- I am aware that an agent of my insurance company, third-party payer, and this professional's insurance administrator may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive. I authorize payment directly to this professional within this Practice. I authorize the use of this signature on all my insurance submissions.
- I have read or heard of our notice of privacy practices, which explains more detail about my rights and how we can use and share your information.
- A photocopy of this assignment is to be considered as good as the original.
- This assignment will remain in effect until revoked by me in writing.
- In consideration of consent, I hereby release the source of the records from any and all liability arising there from.
- I have read and agree with the aforementioned areas in this document. I have had an opportunity to clarify any questions and discuss any points of concern before signing.
- I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

Name (printed): _____ Witness:_____

Signature: _____ Date:_____

Signature of Authorized Person (if applicable): _____Relationship: _____

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# Neuropsychological/Psychological Intake Form – Adult Form

*Please complete this form to the best of your abilities.* Your responses will provide us with information that will help us get to know you and your background. We are particularly concerned about characteristics or experiences that can affect thinking abilities and emotional well-being. Please answer the questions honestly. Information will be kept confidential as indicated in the privacy notice. We will review this form with you, and you will have a chance to discuss your answers and clarify any questions. Thank you! ****PLEASE SUBMIT YOUR COMPLETED FORMS TO INFO@AAANEUROPSYCH.COM BEFORE YOUR APPOINTMENT****

## *A. Basic Identification*

Today's date: _____

Name: _____Date of birth: _____ Pronouns:_____
Ethnicity: _____ Handedness: _____ Native language: _____

## *B. Medical and Neurological History*

Please list your current medical diagnoses: _____
_____

Please list any surgeries and dates: _____

List *all* Medications you are currently taking or have taken in the last year. If you have a list, you can provide a copy.

| Medication | Dose | How often? | Date started? | Reason to take it? | Prescribed by? | Is it effective? |
|---|---|---|---|---|---|---|

List any Vitamins/Supplements that you are currently taking: _____

List any other relevant medications taken in the past: _____

Have you had any of the following general *medical problems*? Check all that apply and specify when they started.

| | |
|---|---|
| ❑Allergies or asthma. Specify: | ❑Heart attack, heart failure or any other heart disease (please circle) |
| ❑High blood pressure | ❑High cholesterol |
| ❑High blood sugar or diabetes | ❑Liver disease, hepatitis, cirrhosis, or jaundice |
| ❑Kidney disease or dialysis | ❑Thyroid disease or other endocrine (gland) disorder |
| ❑Vitamin deficiency. Specify: | ❑Cancer. Specify: |
| ❑Pain. Specify: | ❑Exposure to toxic chemicals |

Other medical problems _____

Have you had any of the following neurological problems? Please indicate all that apply.

| | |
|---|---|
| ❑Head injury or concussion | ❑Loss of oxygen, choking, drowning, or suffocation |
| ❑Seizures, epilepsy, or "fits" | ❑Drug or alcohol overdose |
| ❑Stroke, brain hemorrhage, "TIA's" or other vascular problem | ❑Headaches or migraines |
| ❑High fever, meningitis, encephalitis, or other brain infection | ❑Parkinson's disease, tremors, movement problems |
| ❑Fainting or dizzy spells | ❑Alzheimer's disease or other dementia |
| ❑Brain tumor or cyst | ❑Multiple sclerosis or other demyelinating disease |

| | |
|---|---|
| ❑Balance problems or falls<br>❑Tremors, dexterity problems, numbness<br>❑Broken bones or injuries<br>❑Vision problems (e.g. blurred/double/floaters/sensitivity)<br>❑Hearing problems (e.g. sensitivity/ringing/interference)<br>❑Taste changes (e.g. unusual/unexpected tastes) | ❑Smell problems (e.g. difficulty identifying odors, unusual/unexpected smells)<br>❑Temperature regulation problems (e.g. feeling hot or cold all the time)<br>❑Changes in sexual interest, ability or activity<br>❑Incontinence with bladder or bowels |

Have you had any of these diagnostic tests?
Brain MRI ❑ Date_____ Results_____
Brain CT ❑ Date_____ Results_____
Brain EEG ❑ Date_____ Results_____
Labs ❑ Date_____Results_____
Sleep Study ❑ Date_____Results_____
Are you satisfied with your sleep? ❑No ❑Yes. # hours of sleep/night _____# daytime naps _____

Do you exercise regularly? ❑No ❑Yes. If yes, how often? _____What type of exercise? _____
Do you wear glasses/contacts? ❑No ❑Yes Do you wear hearing aids? ❑No ❑Yes
Do you use a cane/walker/wheelchair? ❑No ❑Yes Are you in pain? ❑No ❑Yes

***C. Family Medical History***

Mother: Alive? ❑No ❑Yes Age (or age at death):_____ Health problems?: _____ Job: _____
Father: Alive? ❑No ❑Yes Age (or age at death):_____Health problems? _____Job: _____
Brother(s): #: ___ Age(s): _____Health problems? _____Sister(s): #: ___ Age(s): _____Health? _____
Your birth order: _____of _____
Children: Names & ages:_____
Do your children have any behavioral or medical problems? ❑No ❑Yes. Specify: _____

Does anyone in your *biological family* have a history of the following? Indicate all that apply

| | |
|---|---|
| ❑Seizures, epilepsy, or "fits"<br>❑Stroke, brain hemorrhage, "TIA's" or other vascular problem<br>❑Heart attack or heart failure or heart disease<br>❑Parkinson's disease or other movement disorder<br>❑Alzheimer's disease or other dementia<br>❑Multiple sclerosis or autoimmune disorder<br>❑Genetic disorders<br>❑Liver, kidney or lung disease | ❑Diabetes, thyroid disease or other endocrine (gland) disorder<br>❑Cancer<br>❑ADD/ADHD<br>❑Learning disability<br>❑ Developmental delays or autism spectrum<br>❑Emotional problems (e.g. depression, anxiety, schizophrenia, bipolar, OCD)<br>❑Problems with drugs or alcohol |

❑Other serious medical or emotional problem? Specify: _____

***D. Psychological History*** Have you ever experienced any of the following?

| | |
|---|---|
| ❑Depression or sad mood<br>❑Suicidality or self-harm<br>❑Angry outbursts or irritability<br>❑Anxiety or stress<br>❑PTSD or trauma<br>❑Phobias or fears<br>❑Obsessions/compulsions (OCD)<br>❑Elated mood or mania | ❑Eating disorder (e.g. anorexia, bulimia)<br>❑Hallucinations (seeing/hearing/feeling things that others don't)<br>❑Delusions (strong beliefs that most others don't share)<br>❑Conversion or somatic symptoms<br>❑Relationship or interpersonal problems<br>❑Social difficulties<br>❑Cultural stress (e.g. racism, sexism, ableism, heterosexism, classism)<br>❑ Acculturation stress (e.g. immigration related) |

❑Other emotional difficulties. Specify: _____

Have you ever been hospitalized for psychiatric reasons? ❑No ❑Yes. Specify: _____
Have you ever had psychological or neuropsychological testing before? ❑No ❑Yes. Specify: _____
Have you ever received psychological, psychiatric or counseling services before? ❑No ❑Yes. Please specify below:

| When? | From whom? | For what? | With what results? |
|---|---|---|---|

Do you consume coffee, soda, tea, or other sources of caffeine regularly? ❑No ❑Yes. # cups/cans per day_____
Do you use tobacco? ❑No ❑Yes. Amount per day_____ If no, did you quit in the past? ❑No ❑Yes. When?_____
Do you drink alcohol? ❑No ❑Yes Did you quit in the past? ❑No ❑Yes. When?_____Current # drinks/week: _____
Do you use cannabis or marijuana? ❑No ❑Yes Did you quit in the past? ❑No ❑Yes. Current use/day: _____
Have you ever used illicit drugs? ❑No ❑Yes. Specify _____
Do you have any DUIs or neglected work/family responsibilities due to your drug or alcohol use? ❑No ❑Yes

***E. Developmental History***

Which city/state/country were you born in? _____
If born outside the US, when immigrated to the US? _____
Do you speak, read, or write in any other languages? _____
What language do you prefer to do your evaluation in? _____

During your *mother's pregnancy* with you, did your mother have any of the following medical problems?

| | |
|---|---|
| ❑Required bedrest or hospitalization for medical problems | ❑Suffered a serious physical injury |
| ❑Used alcohol, tobacco, or non-prescription drugs | ❑Other _____ |
| ❑Used prescribed medication other than vitamins | ❑No problems during mother's pregnancy |
| ❑Was exposed to lead, solvents, or other toxic substances | ❑I don't know |

During *your birth*, were there any of the following problems or complications?

| | |
|---|---|
| ❑Born prematurely | ❑Treated in Intensive Care Unit after your birth |
| ❑Had the cord wrapped around your neck at birth | ❑Other birth complications |
| ❑Lack of oxygen or other fetal distress | ❑No problems during my birth |
| ❑Low "APGAR" scores (poor vital signs at birth) | ❑I don't know |

Did you experience any of the following delays in your *development* as a child?

| | |
|---|---|
| ❑Walking late (after 1 ½ year of age) | ❑Social delays |
| ❑Talking late (after 2 years of age) | ❑Other delays |
| ❑Bedwetting (after 5 years of age) | ❑Typical developmental milestones |
| ❑"Tics" (involuntary movements/sounds such as grunting) | ❑I don't know |

Do you have a childhood history of any of the following (known or suspected)?

| | |
|---|---|
| ❑Head injury or concussions | ❑Learning disabilities |
| ❑Seizures | ❑ADD/ADHD |
| ❑Speech problems | ❑Speech Therapy |
| ❑Autism spectrum disorder | ❑Physical Therapy |
| | ❑Occupational Therapy |

How would you describe your childhood home? (check all that apply)
❑Happy ❑Calm ❑Stressful ❑Abusive ❑Neglectful ❑Fearful ❑Unstable ❑Parental divorce or separation ❑Other

If you are aware, how was your childhood temperament described?
❑Happy ❑Easy ❑Cranky ❑Withdrawn ❑Shy ❑Scared ❑I don't' know ❑Other _____

Have you experienced any of the following ? ❑Physical abuse ❑Sexual abuse ❑ Emotional abuse ❑Neglect ❑Not sure ❑Other _____

***F. Educational History*** Please briefly list information about your *high school and/or college/trade schools*

| School Name | Graduation Year | Grades/~GPA | Major | Degree | Any accommodations? |
|---|---|---|---|---|---|

Best subject(s): _____ Worst subject(s):_____ Required tutoring/special support? ❑No ❑Yes
Failed or repeated any grades? ❑No ❑Yes _____ Known SAT/standardized test scores? _____
Had/have IEP or 504 plan? ❑No ❑Yes _____ Specify: _____

***G. Occupational History***

Are you currently Employed: ❑No ❑Yes.
❑ Full time work ❑ Part time work ❑ Retired ❑ Student ❑ Government assistance ❑ Short/long term disability
❑ Unemployed ❑ Homemaker ❑ Other

Briefly describe your *current and past employment* history:

| Dates of employment | Place of employment | Job Title | Job Duties | Any job problems? |
|---|---|---|---|---|

Have you done any kind of work where you were exposed to toxic chemicals? ❑ No ❑ Yes. Specify: _____

Military Service? ❑No ❑Yes Service Branch:_____Rank at discharge:_____ Position: _____
Year of enlistment: _____Year of discharge: _____ Honorable discharge? ❑ No ❑ Yes. Combat?❑No ❑Yes

***H. Social History***

Current living arrangement: ❑Independent ❑Roommate ❑With partner ❑With children ❑With parent ❑ Other _____
Are you currently in a romantic relationship? ❑No ❑Yes. How long?_____
Are you married? ❑No ❑Yes. How long?: _____ Prior divorces? ❑No ❑Yes. # of times:_____ When?_____
Would you describe your current marriage/relationship as ❑Supportive ❑Neutral ❑Stressful ❑Destructive ❑Other

Are there any other aspects of your identity that you would like to share with us to help us understand you better (e.g. spiritual/religious, LGBTQ2+, indigenous heritage)? _____

What are your hobbies/interests? _____

What do you consider to be your strengths? _____

What is your biggest challenge/stressor right now? _____

Who do you consider to be part of your support network? _____

Do you have an Advanced Directive, Living Will and/or Durable Power of Attorney? ❑No ❑Yes ❑Unsure
.
**Did you complete this form ❑Independently or were you ❑Helped by someone?** Specify who _____

***Thank you for providing this information. We will meet with you to discuss this form further.*** ****PLEASE SUBMIT YOUR COMPLETED PACKET TO INFO@AAANEUROPSYCH.COM BEFORE YOUR APPOINTMENT****