Next Generation Neuropsychology, LLC

Welcome to Next Generation Neuropsychology!

You are being asked to complete the following forms prior to your initial appointment. We understand that you may not have access to all of your early medical and developmental information, so we kindly ask that you complete only the sections that you can.

Should you have any questions or concerns regarding any of the forms, please don't hesitate to contact us at (856) 528-5075.

Thank you for allowing our providers to care for you.

We are excited to meet you!

-Next Generation Neuropsychology

750 Route 73 South ♦ Suite 310B ♦ Marlton, NJ 08053
79 Old Clinton Road ♦ Flemington, NJ 08822
Telephone: (856) 528-5075
Fax: (205) 794-5269

Consent to Treat/Informed Consent Form

I _____give permission for **Next Generation Neuropsychology, LLC** to provide a Neuropsychological Evaluation or Therapeutic Services. By signing this document, I am agreeing to participate in these services and am acknowledging my understanding of them. The type and extent of the services that I will receive will be determined following a discussion with the clinician and other providers involved in my care.

I understand that all information is confidential and no information will be released without my consent. If during the course of treatment, it is necessary for the provider to communicate with anyone else involved in my care, I will be asked to sign a release authorizing which information is to be communicated.

I understand that there are specific and limited exceptions to this confidentially which include:

- **If there is a risk of imminent danger to a child or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.**
- **If there is suspicion that a child is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.**
- **If there is a court order issued for medical records, the clinician and the agency are bound by law to comply with such requests.**

By signing below, I hereby acknowledge that I fully understand my rights and agree to the terms above.

In addition, services provided at Next Generation Neuropsychology are not intended to provide crisis or emergency care and I understand that I will contact 9-1-1 in those situations. The office **does not** have a 24-hour emergency number.

_____ _____

Patient Signature Date

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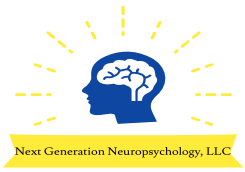

Consent to Send SMS Invitation

In order to remain complaint with HIPPA and insurance guideline, you must provide your consent to receive invitations via SMS or through email from doxy.me, your provider, or appointment reminders. If you agree to the following, please provide your signature of consent.

— I have given consent to receive SMS messages from Next Generation Neuropsychology.

— I am aware of the possibility that data and messages rates may apply.

— I am aware that messages may be sent for appointment or session information.

— I am aware of the following opt-out instructions:

- Reply “CONFIRM” to confirm appointments
- Reply “STOP” to opt out

- I do not consent to receive text messages.

_____	_____	_____
Signature of Patient or Legal Representative	Print Patient or Legal Representative Name	Date

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Next Generation Neuropsychology, LLC

Telehealth Informed Consent

Telehealth is healthcare provided by any means other than a face-to-face visit (e.g., telephone consultation, videoconferencing, e-health, patient portals, etc.). In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, and education. Health information is exchanged through electronic communication.

(Please initial at each statement if you agree)

— I understand that telehealth involves communication of my mental health information in an electronic or technology-assisted format. At Next Generation Neuropsychology, we use the doxy.me platform.

— I understand that I may opt out of telehealth at any time.

— I understand that telehealth services can only be provided to patients, including myself who are residing in the state of New Jersey at the time of this service.

— I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined by my insurance carrier.

- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure platform is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - Electric communication being forwarded, intercepted, or even changed without my knowledge and despite taking reason able measures.
    - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

— I agree that information exchanged during my telehealth visit will be maintained by the clinical psychologist or post-doctoral fellow involved in my care.

— I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own records (and copies of medical records).

— I understand that Skype, Face Time, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

— The mental health provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

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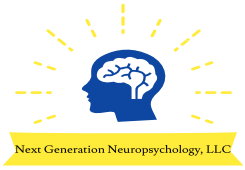

By signing below, I understand the inherent risks of error or deficiencies in electronic transmission of health information and images during a telehealth visit.

To the extent permitted by law, I agree to waive and release Next Generation Neuropsychology practice and staff from any claims I may have about the telehealth visit.

I understand that electronic communication should never be used for emergency communication or urgent requests. In case of an emergency, I will contact my 9-1-1 or my local hospital emergency room department.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

This certifies that electronic communication will take place between _____

(Provider Name) and _____ (Patient's Name).

_____	_____	_____
Signature of Patient or Legal Representative	Print Patient or Legal Representative Name	Date

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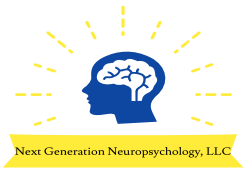

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can receive access to this information.

Please review it carefully

At Next Generation Neuropsychology, LLC patient health information is very important. We use and disclose health information for treatment or payment purposes. For example:

Uses or Disclosures of Health Information

We may use or disclose your health information to a physician, healthcare provider, or educational staff providing treatment to you with consent.

In addition to our use of your health information, you may give us written authorization to use the information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

We will not sure your health information for marketing communications without your written authorization.

We may use or disclose your health information when we are required to do so by law or national security activities.

We may disclose your health information to appropriate authorizes when we suspect abuse or neglect.

We may use or disclose your health information to provide you with appointment reminders, voicemail messages, postcards, or letters.

Patients Rights

You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will locate and copy your information and mail copies to you.

You have the right to request that we amend your health information. Please allow 5 days for this request.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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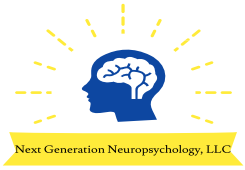

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office (Dr. West-Gavin).

Print Patients Name: _____ Date_____

I, _____acknowledge that I
(Signature of Patient or Legal Guardian)

have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

I, _____ consent to the use and disclosure of
(Signature of Patient or Legal Guardian)

my personal health information by your office for Treatment or Billing as outlined in the NOTICE OF PRIVACY PRACTICES.

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Next Generation Neuropsychology, LLC

Patient Financial Responsibility

Next Generation Neuropsychology LLC is only a covered provider under **Horizon Blue Cross/Blue Shield and Cigna insurance companies**. As such, I understand that I am financially responsible for the neuropsychological evaluation and/or therapeutic services at the time of service, unless I participate with Horizon Blue Cross Blue Shield or Cigna. Any outstanding balances will be mailed monthly. I understand that it is my responsibility for making payments within 30 days of the date that appears on the billing invoice. Any outstanding invoices that exceed 90 days, may be submitted to 3rd party billing collections.

Out-of-network patients: Due to the variation and complexity of medical insurance policies, I am aware that it is my responsibility to contact my insurance provider and receive specific information regarding the reimbursement procedure, including any necessary prior authorizations, prior to the service(s) being rendered. Next Generation Neuropsychology will not be responsible for determining my out-of-network benefits. If information regarding specific CPT codes will be required for out-of-network benefit information, I will contact the office main number at (856)-528-5075 and the codes will be provided. I understand that I am expected to provide out-of-network payments on the day the service is rendered and a receipt or superbill will be provided. Prior to services being rendered, I received a "Good faith estimate."

Please note: It is the patient's responsibility to contact your insurance company to verify if therapeutic services and evaluations are covered by your individual policy.

By my signature below, I hereby authorize financial responsibility for services provided through Next Generation Neuropsychology, LLC. In addition, I provide authorization for Next Generation Neuropsychology, LLC to submit claims on my behalf to the participating insurance companies, which include, Horizon Blue Cross Blue Shield and Cigna.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Signature of Patient/Legal Guardian Date

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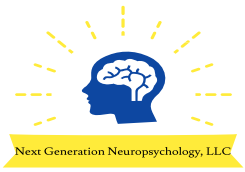

New Patient Information Packet

Patient Name: _____ Nickname: _____

Date of Birth: _____

Handedness: Right Left Ambidextrous Phone Number: _____

Insurance Card Information

Insurance _____ Member ID_____

Insurance phone number_____

Insurance Address_____

Subscriber name_____ Group Number_____

Subscriber Date of birth_____

Home Address _____
_____
_____

Evaluation Purpose:

1. What are the specific questions you have that prompted this evaluation?
   _____
   _____
   _____
   _____
2. Is this evaluation for the purpose of assessing for an Autism Spectrum Disorder? ☐ Yes ☐ No

   If you were previously diagnosed, at what age did the evaluation occur? _____

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Please provide any additional information you have regarding the Autism diagnosis_____
_____
_____

3. Will this be your first neuropsychological evaluation? ☐ Yes ☐ No

If not, please provide information regarding the previous evaluation(s):_____
_____

Pregnancy/Birth History

1. Do you have an adoption history? ☐ Yes ☐No

2. Did your mother receive regular medical care during the pregnancy? ☐ Yes ☐No

Any illnesses or complications while pregnant? ☐ Yes ☐No
If yes, please explain
_____

Medications taken during pregnancy: ☐ Yes ☐No
If yes, please explain
_____

Substances used during pregnancy: ☐ Yes ☐No

☐Cigarettes How many? _____ per (☐day ☐week)
☐Alcohol How many drinks? _____ per (☐day ☐week ☐month)

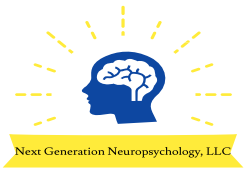
Was your father taking any medications or substances at conception? ☐ Yes ☐ No

If yes, please explain
_____

3. Describe your birth/delivery (please check)

On time (37-42 weeks) __ Premature (number of weeks) ___ Late (number of weeks) ___

4. Were there any complications/unexpected events during delivery? ☐ Yes ☐ No



Birth Weight _____lbs. _____ounces.

5. Did you require any special care following birth? ☐ Yes ☐ No

If yes, please explain_____

Medical History:

1. Do you have any medical diagnoses? If yes, please specify the year of diagnosis and provider:

_____
_____
_____

2. Do you have any allergies? ☐ Yes ☐ No

_____
_____
_____

3. Have you had any surgeries/hospitalizations? ☐ Yes ☐ No

_____
_____
_____

4. Have any of the following neurodiagnostic procedures been performed? If so, when?

CT scan_____
MRI of brain _____
EEG_____
Other (PET, SPECT, etc.)_____

5. Do you experience any sleep related difficulties? ☐ Yes ☐ No
   - ☐ Difficulties with sleep onset
   - ☐ Excessive waking during the night
   - ☐ Snoring
   - ☐ Difficulty waking in the morning
   - ☐ Recent sleep consultation/sleep study

6. Are you currently taking any medication? ☐ Yes ☐ No

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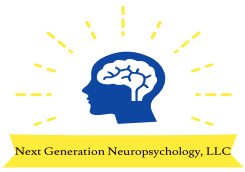


(Please list below)

Current Medication(s)	Dosage	Reason for Medication/Prescriber
Previous Medication(s)	**Dosage**	**Reason for Medication/Prescriber**

7. Date of last hearing test: _____ Were the results normal? ☐Yes ☐No

Do you wear corrective lenses? ☐Yes ☐No

8. Date of last vision test: _____ Were the results normal? ☐Yes ☐No

If no, please explain: _____

Developmental History:

1. Did you achieve your developmental milestones within age-appropriate timeframes?

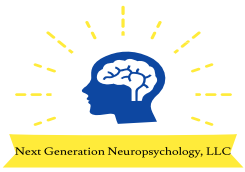
Speech/language: ☐ Yes ☐ No

Gross motor ☐ Yes ☐ No

Fine motor ☐ Yes ☐ No

Social Difficulties ☐ Yes ☐ No

If yes, please explain: _____



2. Did you have a regression or loss of any skills? ☐ Yes ☐ No

If yes, please explain: _____

3. Did you receive Early Intervention Services (EI)? ☐ Yes ☐ No

If yes, at what age did services begin?_____

☐ Behavioral Intervention
☐ Developmental Instruction
☐ Speech/Language Therapy
☐ Occupational Therapy
☐ Other: _____

4. Do you have any sensory sensitivities ☐ Yes ☐ No
(e.g., loud noises, textures, food, etc.)

If "yes" please specify.
_____
_____
_____

Behavioral History:

Please circle all of the following that apply to your personality or behaviors:

sad happy leader follower mood friendly easy going

perfectionistic anxious moody depressed nervous angry funny

quiet overactive independent dependent sensitive affectionate

fearful cooperative lethargic too responsible obsessive/compulsive

hard to discipline even-tempered impulsive social rigid aggressive

other: _____

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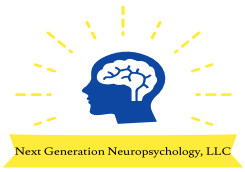

1. Have you ever received services from a behavior specialist (ABA)? ☐ Yes ☐ No

2. Have you ever received in-home therapeutic care? (PerformCare) ☐ Yes ☐ No

3. Have you ever been evaluated in a crisis center? ☐ Yes ☐ No

If "yes" please elaborate (dates/locations)

_____

_____

Educational/Occupational History:

High School/GED: _____ School District:_____

1. Did you have a 504 Accommodation Plan or Individual Education Plan (IEP)? ☐ Yes ☐ No

Did you receive?

Speech/Language Therapy	☐ Yes ☐ No
Occupational Therapy	☐ Yes ☐ No
Aide Support	☐ Yes ☐ No
Resource Room Support	☐ Yes ☐ No
Counseling	☐ Yes ☐ No
Extended School Year (ESY)	☐ Yes ☐ No

2. What were your grades? _____

3. Did you have any academic difficulties? ☐ Yes ☐ No

If yes, in what subjects?

_____

_____

4. What were you areas of strength in school?_____

5. Have you graduated or are you currently attending college or a certification program? ☐ Yes ☐ No

College/Program Name: _____

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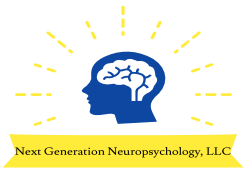

Program Degree: _____

Year Started: _____

Credits earned:_____

6. Are you currently employed? ☐ Yes ☐ No

If yes, please provide employment details: _____
_____
_____
_____

Please provide additional information regarding previous employment positions: _____
_____
_____
_____
_____

Family Medical History:

Current Relationship Status: Married Divorced Separated Unmarried Domestic Partnership

Do you have any children? ☐ Yes ☐No

Parental Information:

Father/Mother Age: _____ ☐ Living ☐ Deceased

Father/Mother Age: _____ ☐ Living ☐ Deceased

Step-parent Age: _____ ☐ Living ☐ Deceased

Step-parent Age: _____ ☐ Living ☐ Deceased

Siblings: Male/Female Age: _____
Male/Female Age: _____
Male/Female Age: _____

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Please indicate if any immediate family members have or had any of the following:

Please indicate with an "x"	Yes	No		Yes	No
Manic Depression			Multiple Sclerosis		
Depression			Diabetes		
Anxiety Disorder			Cancer		
Obsessive-Compulsive Disorder			Heart Disease		
Learning Disabilities			Thyroid Problems		
Autism Spectrum Disorder			Headaches		
Phobias/Fears			Epilepsy/Seizures		
Speech/Language Delay			High Blood Pressure		
Hallucinations			Drug Abuse/Dependence		
Schizophrenic			Alcohol Abuse/Dependence		
Tourette's Syndrome			Intellectual Disabilities		
AD/HD			Brain Injury		

If "yes" please elaborate:

_____

_____

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from problems with inattentiveness or hyperactivity; epilepsy; seizures; migraines; alcoholism or substance abuse; psychological, emotional, or personality difficulty; learning problems or developmental disabilities; and/or a "nervous" or neurological disorder; etc.?

☐**Yes** ☐**No** If yes, please list their relationship to you and known diagnosis.

Maternal (mother's side)

_____

_____

_____

_____

Paternal (father's side)

_____

_____

_____

_____

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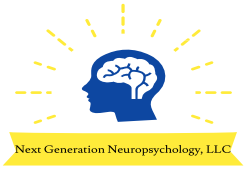

Referral Questions:

Please specify if any behaviors or challenges that exist.

_____
_____
_____
_____

What services or interventions have been previously performed (if any)?

_____
_____
_____
_____

Please provide any additional information that you believe may be helpful.

_____
_____
_____

Signature _____ Date:_____

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