Next Generation Neuropsychology, LLC

Welcome to Next Generation Neuropsychology!

You are being asked to complete the following forms prior to your child's initial appointment.

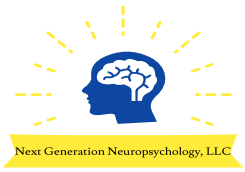
Should you have any questions or concerns regarding any of the forms, please don't hesitate to contact us at (856) 528-5075.

Thank you for allowing our providers to care for your child.

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 to my child _____. By signing this document, I am agreeing to their participation 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 child's care.

Joint and Shared Legal Custody (Please initial if you agree)

— Due to the complexities of divorce, separation, child custody, and visitation disputes, we require consent from both parents prior to the commencement of therapeutic or evaluative services of minors. In order to prevent any disruption of care, we ask that you inform the staff prior to scheduling appointments.

I understand that all information is confidential and no information will be released without consent. If during the course of treatment, it is necessary for the provider to communicate with anyone else involved in my child's 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 on behalf of my child.

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.

_____ _____

Parent/Guardian Name and Signature Date

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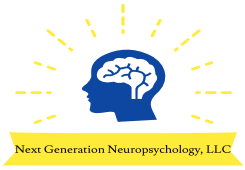

Consent to Send SMS Invitation

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

o I do not consent to receive text messages.

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

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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 each statement if you agree)

— I understand that telehealth involves communication of my child'smental 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 child's 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.

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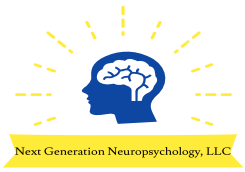

— The mental health provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

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 Parent or Legal Representative	Print Parent or Legal Representative Name	Date

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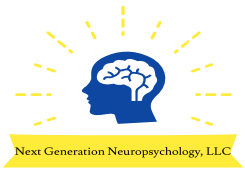


Notice of Privacy Practices

This notice describes how health information about you or your child 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 or your child with consent.

In addition to our use of your child's 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.

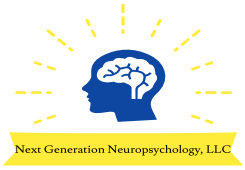
We may use or disclose your health information to provide you with appointment reminders, voicemail messages, postcards, or letters.

Patients Rights

You have the right to look at or get copies of your child's 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.

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 Parent 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 Parent 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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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 Parent/Legal Guardian Date

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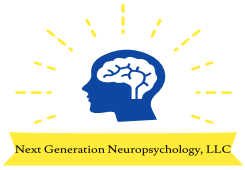

New Patient Information Packet

Patient Name: _____ Nickname: _____

Date of Birth: _____ Current Grade: _____

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_____

Family Home Address _____
_____
_____

May we have your permission to speak with you in front of your child about your concerns?

☐ Yes ☐ No

If you prefer not to speak in front of your child, please provide a contact number for clinical discussions regarding your concerns (____)_____

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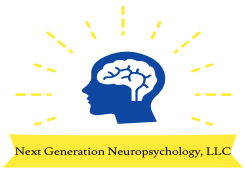

***Evaluation Purpose**:*

1. What are the specific questions you have regarding your child?

   _____
   _____
   _____
   _____

2. Is this evaluation for the purpose of assessing for an Autism Spectrum Disorder? ☐ Yes ☐ No

   If your child was previously diagnosed, at what age did the evaluation occur? _____

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

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

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

Pregnancy/Birth History

1. Does your child have an adoption history? ☐ Yes ☐No

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

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

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

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Substances used during pregnancy: ☐ Yes ☐No

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

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

If yes, please explain
_____

3. Describe your baby's 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 your baby require any special care following birth? ☐ Yes ☐ No

If yes, please explain_____

6. Once home, did your child have any difficulties (e.g., feeding)? ☐ Yes ☐ No

If yes, please explain_____

Medical History:

1. Does your child have any medical diagnoses? If yes, please specify the year of diagnosis and provider:
_____
_____
_____

2. Does your child have any allergies? ☐ Yes ☐ No
_____
_____
_____

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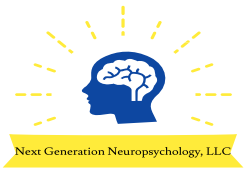

3. Has your child had any surgeries/hospitalizations? ☐ Yes ☐ No

_____

_____

_____

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

CT scan_____

MRI of brain _____

EEG_____

Other (PET, SPECT, etc.)_____

5. Does your child experience any sleep related difficulties? ☐ Yes ☐ No

- ☐ Difficulties with sleep onset
- ☐ Excessive waking during the night
- ☐ Co-sleeping
- ☐ Snoring
- ☐ Difficulty waking in the morning
- ☐ Bedwetting
- ☐ Recent sleep consultation/sleep study

6. Is your child currently taking any medication? ☐ Yes ☐ No

(Please list below)

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

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

Does you child 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 your child achieve his/her developmental milestones within age-appropriate timeframes? Please indicate the age of onset.

Speech/language: ☐ Yes ☐ No

Spoke first word at age:_____
Combined one-two words:_____
Simple phrases: _____
Sentences:_____

Gross motor ☐ Yes ☐ No

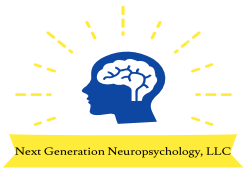
Fine motor ☐ Yes ☐ No

Social Difficulties ☐ Yes ☐ No

If yes, please explain: _____

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

If yes, please explain: _____



3. Did/Does your child 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. Is your child toilet trained? ☐ Yes ☐ No
At what age: _____

5. Does your child have toileting accidents? ☐ Yes ☐ No

6. Does your child 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 child's 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. Has your child ever received services from a behavior specialist (ABA)? ☐ Yes ☐ No

2. Has your child ever received in-home therapeutic care? (PerformCare) ☐ Yes ☐ No

3. Has your child ever been evaluated in a crisis center? ☐ Yes ☐ No

If "yes" please elaborate (dates/locations)

_____

4. Does your child have any hyper-sexualized behaviors? ☐ Yes ☐ No
(e.g., fascination with genitals or use of highly sexual words, interest in things of sexual nature, etc.)

5. Does your child have a history of exposure to:
☐ Physical Abuse
☐ Sexual Abuse
☐ Neglect
☐ Domestic Violence

If "yes" please explain:

_____

_____

Educational History:

Current School: _____ School District:_____

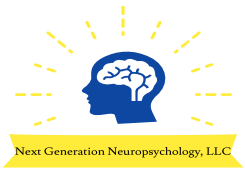
1. Does your child have a 504 Accommodation Plan or Individual Education Plan (IEP)? ☐ Yes ☐ No

If your child has an IEP, what is the education classification: _____

Are the accommodations beneficial? _____

Does your child currently 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. Has your child undergone recent evaluations through the Child Study Team ☐ Yes ☐ No

3. Has your child ever repeated a grade? ☐ Yes ☐ No

4. What are your child's grades? _____

5. Does your child have any academic difficulties? ☐ Yes ☐ No
If yes, in what subjects?
_____
_____

6. Has the teacher(s) reported any concerns? ☐ Yes ☐ No

If yes, please explain: _____

7. What are your child's areas of strength in school?_____

Briefly described your child's performance and any concerns in the each grade:

Preschool: _____

Kindergarten: _____

Elementary School: _____

Middle School: _____

High School: _____

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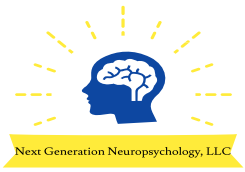

Family Medical History:

Relationship Status: Married Divorced Separated Unmarried Domestic Partnership

Is there a custody agreement or court order regarding parenting: □ Yes □No

Father/Mother Age: _____ Occupation:_____ □ Living □ Deceased

Father/Mother Age: _____ Occupation:_____ □ Living □ Deceased

Stepmother Age: _____ Occupation:_____ □ Living □ Deceased

Stepfather Age: _____ Occupation:_____ □ Living □ Deceased

Siblings: Male/Female Age: _____ Resides with patient □ Yes □No
Male/Female Age: _____ Resides with patient □ Yes □No
Male/Female Age: _____ Resides with patient □ Yes □No

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:

_____

_____

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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 your child and known diagnosis.

Maternal (mother's side)	Paternal (father's side)
_____	_____
_____	_____
_____	_____
_____	_____

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:_____

Individual completeing forms

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