Neurobehavioral Consultants, P.C.

Dear Prospective Client,

Welcome to Neurobehavioral Consultants, P.C. We are honored and pleased that you have chosen our office for therapeutic and/or evaluation services. We are confident that our staff (neuropsychologist, psychologist, professional counselor, and speech pathologist) will meet or exceed your expectations for your child or teen. We specialize in the assessment and treatment of a wide range of problems, including attention deficit hyperactivity disorders, learning disabilities, anxiety and mood disorders, behavioral problems, and neurobehavioral conditions.

We request that you complete the New Patient Packet and bring all the forms to your first appointment. The completion of these forms will allow us to spend more time together, rather than focusing on paperwork. Included in this packet are:

- Patient Information Form
- Patient Services Agreement
  - Professional Fees
  - Appointments and Cancellation Policy
  - HIPAA Notice of Privacy Practices
  - Limits of Confidentiality
- Problem Checklist
- Child History Form
- Handling of Confidential Health Information
- Credit Card Authorization Form
- Authorization for Release of Information
- Directions to Neurobehavioral Consultants, P.C.

Forms should be completed by the custodial parent or guardian.

Should you have any questions prior to your first appointment, please contact our administrative staff for assistance. We are looking forward to working with you and appreciate the opportunity to assist you and your child in reaching treatment goals.

Sincerely,

Jay Inwald, Psy.D, LP
Pediatric Psychologist and Neuropsychologist

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
(248) 723-9200 • Fax (248) 723-9218 • admin@neurobehavioralconsultants.com

PATIENT INFORMATION FORM

Patient Name: _____
First Middle Last

DOB: _____ Male _____ Female_____ Email: _____

Address: _____ Apt. _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

ALTERNATE CONTACT:

Name: _____ Relationship: _____

Phone: _____ Email: _____

ADDITIONAL INFORMATION FOR PARENT(S)/GUARDIAN(S)

Name(s): _____

Relationship: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

___ Check if this individual is the financial responsible party.

Name(s): _____

Relationship: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

___ Check if this individual is the financial responsible party.

INSURANCE INFORMATION:

Primary Insurance Company: _____ Patient's ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance Company: _____ Patient's ID: _____

Subscriber Name: _____ Subscriber DOB: _____

_____ _____ _____
Signature* Date Relationship to Patient

_____ _____ _____
Print Name Print Patient's Name Patient's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parent's signatures are required. Only one parent's signature is required if parents are married to each other.

_____ _____ _____
Additional Parent Signature Date Relationship to Patient

_____
Print Name

Neurobehavioral Consultants, P.C.

Patient Services Agreement

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations. We are required to obtain your signature acknowledging that we have provided you with this information prior to your first session. It is very important that you read these documents carefully before your first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation cannot be retroactive and cannot prevent us from meeting obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy, or from taking steps to collect if you have not satisfied any financial obligations you have incurred with us.

PROFESSIONAL FEES

In addition to the fees for weekly appointments, we may charge a pre-determined amount for other professional services you may need. Other services for which you may be billed include request for letters or narratives, conversing with you by telephone if the conversation lasts longer than 5-10 minutes, consulting with other professionals with your permission, preparation of treatment summaries or disability, work, or other similar forms, and the time spent performing other services you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party.

APPOINTMENTS AND CANCELLATION POLICY

Your insurance company will be billed for services provided. Insurance may not cover all fees. If insurance does not cover the full fee, you are responsible for the remainder of the full fee unless prohibited by provider agreement with your insurance company (e.g., Blue Cross). Therefore, your actual payment to Neurobehavioral Consultants, P.C. may be greater than the standard co-pay required by your insurance company. Co-payments, deductibles, and coinsurance payments are due at the time of service. We must have complete insurance information from you in order to bill for services.

Your insurance policy is a contract between you and the insurer, and ultimately, you are responsible for any fees not paid by your insurance company. Therefore, please contact your insurance company directly to ensure that you have received the most accurate and reliable information regarding your outpatient mental health benefits.

31600 Telegraph Road • Suite 230 • Bingham Farms, Michigan 48025
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For your convenience, we accept cash, checks, and Visa, MasterCard, Discover, and American Express.

Upon request, we will be happy to discuss payment plan options with you.

A $5.00 per month statement fee will be added to balances over 30 days.

Reports/letters will not be released until all balances are paid in full.

If your account is turned over to a collection agency due to delinquency of your account, you shall be responsible for a $200 collection fee and any attorney fees charged to Neurobehavioral Consultants, P.C. by the collection agency.

Our policy is to charge for missed appointments at the rate of $100.00 per individual session, unless canceled at least 24 hours in advance. A testing day will be charged at a rate of $500.00, if not given 48 hour cancellation notice. Payment will be required prior to the next scheduled appointment. If payment is not received, then the scheduled appointment time is forfeited, as well as all future appointments. If two consecutive appointments are not attended, you will forfeit your regularly scheduled appointment time. Please help us serve you better by keeping all scheduled appointments.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health care operations.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include psychotherapy.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of funding our practice, such as conducting quality assessment and improvement activities, auditing functions,

cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend you protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257/Toll Free: 1-877-696-6775

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. These are situations that require you to provide written, advanced consent.

Your signature on the agreement provides consent for those activities as follows:

- Disclosures required by health insurance carriers to collect fees.
- If a client threatens to harm him/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. There are some situations where we are permitted or required to disclose information without either your consent or authorization:
    - If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is protected by the psychologist-client privilege law. We cannot provide any information without your written authorization or a court order. If you are involved in, or contemplating, litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
    - If a government agency is requesting the information for health oversight activities.
    - If a client files a complaint or lawsuit against our office, we may disclose relevant information regarding that client in our defense.
    - If a client files a worker's compensation claim, and we are providing treatment related to the claim, we must, upon appropriate request, furnish copies of all psychological reports and bills.

There are some situations in which we are **legally obligated** to take action, and which we believe are necessary, to attempt to protect others from harm. We may have to reveal some information about a client's treatment. In our practice, such situations are unusual. These are the types of situations in which we are legally obligated to break confidentiality:

- If we have reason to believe that a child has been abused, the law requires that we file a report with the appropriate government agency.
- If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report this suspected abuse.
- If we determine that a client presents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such situations arises, we will make every effort to fully discuss it with you **before** taking any action and will limit our disclosure to what is necessary.

Neurobehavioral Consultants, P.C.

OFFICE FILE COPY

Your signature below indicates that you have read the Patient Services Agreement and that you agree to its terms. It also serves as an acknowledgement that you have received the HIPAA notice.

Signature*	Date
Print Name	Relationship to Patient
Print Patient's Name	Patient's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parent's signatures are required.

Only one parent's signature is required if parents are married to each other.

Additional Parent Signature	Date
Print Name	Relationship to Patient

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Neurobehavioral Consultants, P.C.

31600 Telegraph Road, Suite 230
Bingham Farms, Michigan 48025

(248) 723-9200
Fax (248) 723-9218

Name: _____ Date of Birth: _____ Parents: _____

Pediatrician/Family Physician: _____ Current Medication(s): _____

PROBLEMS (Observed/Reported)

Please indicate any problems that your child is **currently having** or has had within the **past six months** only.

LIST 1

Annoying Behavior (seems intentional)	
Argumentative	
Avoidance (e.g. people, places, activities)	
Binge Eating	
Blames Others	
Controlling	
Deceitful	
Defiance	
Difficulty Concentrating	
Difficulty Organizing	
Diminished Appetite	
Disturbed Body Perception	
Easily Distracted	
Energy Changes	
Excessive or Intense Fears	
Fasting	
Fatigue	
Feelings of Guilt or Worthlessness	
Flight of Ideas	
Hyperactive	
Hyper-Vigilance	
Immature For Age	
Inattentive	
Insomnia	
Interrupts	
Irritability	
Labile	
Lack of Empathy	
Little or No Motivation	
Loss of Temper	
Low Self-Esteem	
Memory Loss	
Motor Restlessness	
Oppositional	
Perfectionism	
Poor Social Skills	
Restricted Emotional Expression	
Sadness	
Social/Occupational Dysfunction	
Suspiciousness	
Talks Excessively	
Tics	
Unable to Follow Directions	
Use of Laxatives, Diuretics, Appetite Suppressants	
Worry	

LIST 2

Accident Prone	
Aggression	
Anxiety	
Body Weight Less Than 85% of Normal	
Depression	
Destruction of Property	
Detachment	
Disorganized Speech	
Excessive Interest (In One Thing or Idea, e.g. dinosaurs, trucks, Middles Ages)	
Impaired Communication (e.g. Delay/Lack of Spoken Language, Repetitive/Idiosyncratic Language)	
Impaired Social Interaction (e.g. No Eye Contact, Blank Facial Expression)	
Impulsivity	
Inflated Self Esteem or Grandiosity	
Irrational Fears (Death, Loss of Control)	
Low Frustration Tolerance	
Mania	
Perceptual or Cognitive Distortion	
Promiscuity	
Purging, Self-Induced Vomiting	
Repetitive Behavior (Hand Washing, Counting)	
Repetitive/Stereotypical Behaviors	
Restrictive Eating	
Serious Violation of Rules (Truancy, Run Away)	
Significant Weight Change	
Sleep Difficulties (Explain)	
Somatic Complaints	
Theft	

LIST 3

Delusions	
Disorganized Behavior	
Dissociation	
Flashbacks	
Hallucinations	
Mood Swings	
Recurrent, Persistent Intrusive Thoughts	
Repeats Words or Stock Phrases	
Self-Harm (Cutting)	
Thoughts of Death	
Use of Weapons (Excessively)	
Violence	
Other:	

Neurobehavioral Consultants, P.C.

Child's History

Please fill out this questionnaire as fully as possible. If you have any questions, you can discuss them with the examiner when the history form is reviewed with you.

Child's Information

Name:_____ Birth Date:_____ Age:_____

Address:_____ Phone:_____

City:_____ Zip Code:_____

Parent/Guardian Name:_____

Parent/Guardian Address:_____

Parent/Guardian Phone:_____

What are the problems that cause you to seek help for this child? (Be specific)_____

_____

_____

Referring Doctor:_____ Phone:_____

Adults in the home:_____

Relationship to child:_____

Is this child adopted?_____ If so, age at adoption:_____

Status of parent's marriage:_____

	Birth Mother	Birth Father
Age:		
Highest Grade Completed:		
Diploma/Degree:		
Occupation:		
Learning Difficulty:		
Behavioral Problems:		
Emotional Problems:		

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Siblings (including step-siblings and half siblings):

Name	Age	Sex	In the home?

Birth and Developmental History

PREGNANCY

Prenatal Care _____Yes _____No

Please describe any complications that occurred during the pregnancy:_____

_____

_____

Substances used **during** the pregnancy?

_____ Cigarettes How many? _____Per day:_____ Per Week:_____
_____ Alcohol How much?_____ Per day:_____ Per Week:_____
_____ Drugs Type and frequency:_____
_____ Medications Type and frequency:_____

LABOR AND DELIVERY

Mother's age at time of birth:_____ Father's age at time of birth:_____

Was the birth premature?_____ If so, how early:_____

Birth weight:_____ Length:_____ APGAR scores:_____

Was this a feet first (breech) delivery?_____ Did you have a Cesarean delivery?_____

Please describe any complications with the delivery:_____

_____

Please describe any health problems the baby had:_____

_____

How long did the child stay in the hospital?_____

Was oxygen used for the baby? ____Yes ____No

Ages at Milestones

Crawled:_____ Walked:_____ Ran Well:_____

Fed Self With Spoon:_____ Scribbled:_____Tied Shoes:_____Ride Two Wheeler:_____

Used Single Words:_____ Used Sentences (2+words):_____ Described Activity:_____

Potty Trained/Day:_____ Potty Trained/Night:_____

Rate of Development Overall: _____ Slow _____ Normal _____ Fast

Medical History

Please describe any serious injuries, illnesses, and/or surgeries your child has had._____

_____

_____

Has the child had a head injury?_____ If so, did he/she lose consciousness?_____

If he/she lost consciousness, for how long?_____ Was he/she comatose?_____

Please describe any other handicapping conditions or special health considerations and their treatments:_____

_____

Date and results of last hearing test:_____

Date and results of last vision test:_____

Please list medications (with dosage and times) currently being taken by the child, including non-prescription medications:_____

_____

_____

BEHAVIORAL AND MENTAL HEALTH HISTORY

Please describe any professional mental health treatment, such as individual, family, or group counseling, that your child has received. Please list name of the counselor, type of treatment, and length of treatment._____

_____

_____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments. Please feel free to use the back of this page if more room is needed._____

_____

_____

EDUCATIONAL HISTORY

Please list the name, location, type of program, number of days per week, age when started, and how your child progressed in preschool and/or daycare programs:_____

_____

_____

Current grade and school:_____

Previous schools attended and grades at each:_____

_____

Briefly describe the child's performance academically and socially in each grade:

Kindergarten:_____

1st Grade:_____

2nd Grade:_____

3rd Grade:_____

4th Grade:_____

5th Grade:_____

Middle School:_____

High School:_____

_____

_____

Has the child been placed in special education programs currently or in the past?_____

_____ Learning Disability (LD): Subjects:_____

_____ Language Disorder: Type:_____

_____ Tutoring: Subjects:_____

Previous Psychosocial Testing:_____

FAMILY HISTORY

For the following questions, please consider the child's parents, siblings, grandparents, uncles, aunts, and cousins).

Please indicate which family members experience the following problems: inattentiveness or hyperactivity; epilepsy; migraines; alcoholism or substance abuse; anxiety, depression, learning problems, developmental disabilities, neurological disorders, or other psychological, emotional and/or personality difficulties:

Mother's side: _____

_____

Father's side: _____

_____

Please add any additional comments you think might be helpful: _____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Signature* Date Relationship to Patient

_____ _____ _____

Print Name Print Patient's Name Patient's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parent's signatures are required. Only one parent's signature is required if parents are married to each other.

_____ _____ _____

Additional Parent Signature Date Relationship to Patient

_____

Print Name

Neurobehavioral Consultants, P.C.

Handling of Confidential Health Information

Communication by Email
Neurobehavioral Consultants, P.C. cannot guarantee confidentiality with electronic communications. It is important that you understand that the nature of the internet is that any emails you send or receive may also be intercepted by other people. Neurobehavioral Consultants, P.C. uses an encrypted email server, but recipient email addresses typically do not (Yahoo, Gmail, Hotmail, AOL, Comcast, etc.). There is an inherent risk to using any unencrypted communication.

After reading the above information, may we communicate with you by email? **Yes** **No**

TeleMedicine
I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but limited to reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
3. Although Neurobehavioral Consultants, P.C. uses HIPAA compliant software, I understand that there are risks and consequences from telemedicine, including but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. I understand that telemedicine-based services and care may not be as complete as face-to-face services. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
5. By signing this document I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer based psychotherapy services. If I am in a crisis or in an emergency, I should immediately call 911 or go to the nearest hospital.

I have read and understand the information provided above.

Signature*	Date	Relationship to Patient

Print Name	Print Patient's Name	Patient's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parent's signatures are required. Only one parent's signature is required if parents are married to each other.

Additional Parent Signature	Date	Relationship to Patient

Print Name

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CREDIT CARD AUTHORIZATION

Because it is not always possible to collect payments from clients at the time of service, we request that you provide us with a credit card number to keep on file.

By signing below, I authorize that the credit card on file may be charged for co-pays, co-insurance or deductible payments due, charges for out of pocket sessions, and balances due at month-end after insurance payments have been posted to my account.

By signing below, I certify that the information provided is true and accurate and that I am an authorized user on the credit care/debit account below. I authorize Neurobehavioral Consultants, P.C. to keep my credit card information on file and charge the amounts due automatically and on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for notifying Neurobehavioral Consultants, P.C. if my credit/debit card information needs to be updated.

_____

PATIENT NAME

_____

CARDHOLDER NAME

_____

BILLING ADDRESS

_____

CITY STATE ZIP

CIRCLE CREDIT CARD TYPE:

MASTERCARD VISA AMERICAN EXPRESS DISCOVER

_____

CREDIT CARD NUMBER

_____

EXPIRATION DATE CV-CODE

_____

CARDHOLDER SIGNATURE

_____

TODAY'S DATE

Neurobehavioral Consultants, P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I hereby authorize Dr. Jay Inwald and/or Neurobehavioral Consultants, P.C., at 31600 Telegraph Road, Suite 230, Bingham Farms, MI 48025, to obtain and/or release any medical, psychiatric, educational, or psychological information to:

_____

_____

_____

I hereby consent to the release of the above medical, psychiatric, educational, or psychological information, which may include drug abuse and mental health records obtained in the course of my diagnosis, assessment and/or treatment. I understand that such information cannot be released without my specific consent, except in a medical emergency or by court order.

I have read and fully understand its contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

I agree that a photocopy of this Release may be accepted if necessary.
This authorization is valid until revoked in writing.

_____	_____	_____
Signature*	Date	Relationship to Patient

_____	_____	_____
Print Name	Print Patient's Name	Patient's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parent's signatures are required. Only one parent's signature is required if parents are married to each other.

_____	_____	_____
Additional Parent Signature	Date	Relationship to Patient

_____
Print Name

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Directions

Address: 31600 Telegraph Road
Suite 230
Bingham Farms, MI 48025

Phone: 248.723.9200

Please Note:

- We are located on the east side of Telegraph Road in an orange brick building.
- You will not see our building from the road. Our building is located behind another, but you cannot get to our parking lot from the lot of the building in front of us.
- Our driveway is immediately after the parking lot for building 31500.
- At our driveway, you will see a black sign with white trim that says **GEORGETOWN**. It also has our building number on it.
- Once you have turned in, you will see building 31700 (two story, orange brick) on the left. Pass building 31700 and turn right, into our parking lot. Building 31600 appears to be a one story building.
- Our suite is located on the main level almost directly across from the entrance.