McKINNEY NEUROPSYCHOLOGY
BEHAVIORAL HEALTH & WELLNESS

Consent for Treatment – Adult

Name _____ Gender _____

Age _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____

Phone (Preferred):_____ (Secondary):_____

Email _____

Does anyone hold power of attorney for you?_____

==========

Please read and initial each:

_____ I give my consent to receive psychological and/or neuropsychological services from clinicians of McKinney Neuropsychology.

_____ I understand that services are provided on a confidential basis and records are disclosed only when properly authorized or required by law.

_____ I acknowledge that I have had an opportunity to review the HIPAA Privacy Policy Form utilized by McKinney Neuropsychology.

This authorization shall remain in effect for one year from the date of signing or until_____.

Patient Name (Print): _____ Date: _____/_____/_____

Patient or Legal Guardian Signature: _____

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:

TX State Board of Examiners of Professional Counselors OR **TX State Board of Examiners of Marriage & Family Therapists**
Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369
http://www.dshs.texas.gov/counselor/
http://www.dshs.texas.gov/mft/default.shtm

TX State Board of Examiners of Psychologists

Investigations and Enforcement Divisions
333 Guadalupe, Ste. 2-450 Austin, Texas 78701
https://www.tsbep.texas.gov

Address | 7300 W Eldorado Parkway Suite 265, McKinney, TX 75070
Telephone | (469) 714-0100
Fax | (469) 714-0205
Email | office@mckinneyneuropsych.com
Website | mckinneyneuropsych.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name McKinney Neuropsychology
Address 7300 W. Eldorado Parkway, Suite 265
City McKinney State Texas Zip Code 75070
Phone (469) 714 - 0100 Fax (469) 714 - 0205

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

McKINNEY NEUROPSYCHOLOGY
BEHAVIORAL HEALTH & WELLNESS

Financial Agreement including
Credit Card Authorization and No Show Policy

Client Name: _____ Client Date of Birth: _____/_____/_____

At McKinney Neuropsychology, we require a credit or debit card on file as a convenient method of payment for the portion of services for which you are liable. Your credit card information is kept confidential and secure. Cash and check payments are always welcomed in lieu of a credit card transaction, though we still require a card on file.

Please read and initial each below, directing questions to the clinicians or office staff:

_____ I understand payment is due at the time of service and the appointment will be rescheduled If this obligation cannot be fulfilled.

_____ I understand insurance companies *do not* consider academic testing medically necessary and therefore do not cover the service. Should I decide to have academic testing, there will be an additional out-of-pocket fee of $500 that will not be billed through insurance.

_____ I understand if I no-show an appointment or cancel without at least *24 hour notice*, the credit card listed below will be charged $75 *per appointment hour missed*.

_____ I understand that if there is a balance on my account, McKinney Neuropsychology will charge the credit card on file after I have been notified. This may include balances due for services rendered the insurance company did not cover.

_____ I acknowledge I am encouraged by this office to review the Explanation of Benefits (EOB) provided to me by my insurance to ensure proper claim processing. Should my insurance overpay for services rendered, I am encouraged to contact McKinney Neuropsychology to request a refund.

_____ Lastly, I understand that if I provide a new or additional card that is not listed on this form, I am giving permission for it to be charged under the same aforementioned criteria.

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Credit Card Number: _____

Expiration Date: _____/ _____ **CVV# (Security Code)** _____

Cardholder Name: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Cardholder Signature: _____

Date: _____/_____/_____

Address | 7300 W Eldorado Parkway
Suite 265, McKinney, TX 75070
Telephone | (469) 714-0100
Fax | (469) 714-0205
Email | office@mckinneyneuropsych.com
Website | mckinneyneuropsych.com

MCKINNEY NEUROPSYCHOLOGY

BEHAVIORAL HEALTH & WELLNESS

Adult Intake Questionnaire

Date: _____

Name: _____ Age: _____ Gender: _____

Birth Date: _____ Race/Ethnicity: _____

Referred by: _____ Primary Care Physician: _____

Reason for your referral_____

MEDICAL HISTORY

Please list any medical conditions or mental health diagnoses you have currently or previously:

	Illness or Serious Injury
1.	
2.	
3.	
4.	
5.	

Current Medications	Dosage	Times per day	Date started	Prescribing Provider

Have you ever had a negative response to any medication?

_____

If yes, what was the medication and what was your reaction?

_____

Please list any previous hospitalizations/operations:

	Condition	Date	Hospital
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Have you ever undergone?		**If yes, when? Results?**
an MRI scan of the brain?	YES NO	
a CAT scan of the brain?	YES NO	
an EEG?	YES NO	
a Carotid Doppler test?	YES NO	
a Sleep Study?	YES NO	
prior Psychological testing and/or a Neuropsychological Evaluation?	YES NO	

Have you ever experienced?

Vision Problems?	NO YES	**Glasses:**	NO YES			
		Glaucoma:	NO YES	Right eye	Left eye	
		Blurring:	NO YES	Right eye	Left eye	
		Double vision:	NO YES			
		Other:				
Hearing Problems?	NO YES	**Hearing aids:**	NO YES	Right ear	Left ear	
		Ringing:	NO YES	Right ear	Left ear	
		Buzzing:	NO YES	Right ear	Left ear	
		Other:				
Stroke?	NO YES					
Head injury?	NO YES					

Episodes where you passed out, blacked out, or fainted (lost consciousness)?	NO YES	Describe:
Other neurological problems?	NO YES	
High Blood Pressure?	NO YES	
High Cholesterol?	NO YES	
Diabetes?	NO YES	Describe:
Seizures?	NO YES	**What type:** Grand Mal Petite Mal Absence **How often:**_____
Headaches?	NO YES	**What type:** Tension Migraine Sinus **How often:**_____
Tremors?	NO YES	Describe:
Balance problems?	NO YES	Describe:
Urinary Incontinence?	NO YES	Describe:
Weakness in any part of your body?	NO YES	Describe:
Numbness in any part of your body?	NO YES	Describe:
Any motor vehicle accidents?	NO YES	**How many accidents?**_____ **Were you seriously injured?** NO YES **Were you hit on the head?** NO YES **Were you knocked out?** NO YES **For how long?**_____ minutes hours days
Are you involved in any lawsuits?	NO YES	
Have you ever been convicted of a crime?	NO YES	

Have you recently experienced:

Brief episodes that included:	
Changes in your vision	NO YES
Tingling in part of your body	NO YES
Weakness in parts of your body	NO YES

Changes in the ability to use your hands?	NO YES	**Due to:** **Hand:** **Weakness:** NO YES RIGHT LEFT **Tremors:** NO YES RIGHT LEFT **Arthritis:** NO YES RIGHT LEFT **Poor Coordination:** NO YES RIGHT LEFT
Problems with your sense of direction?	NO YES	MILD MODERATE SEVERE
Problems with your sense taste?	NO YES	MILD MODERATE SEVERE
Problems with sense of smell?	NO YES	MILD MODERATE SEVERE
Problems with nausea?	NO YES	MILD MODERATE SEVERE
Had recent changes in weight or appetite?	NO YES	**Appetite change:** MILD MODERATE SEVERE **Weight change:** _____Pounds Loss or Gain
Felt depressed recently?	NO YES	MILD MODERATE SEVERE
Experienced anxiety recently?	NO YES	MILD MODERATE SEVERE
Past mental health diagnoses and/or treatment?	NO YES	
Heard or seen things that others have not?	NO YES	
Are you currently thinking about suicide?	NO YES	
Have you ever thought about or attempted suicide?	NO YES	
Have there been changes in the way you get along with your family members?	NO YES	MILD MODERATE SEVERE **Please describe:**
Has anyone noticed changes in your personality?	NO YES	MILD MODERATE SEVERE **Please describe:**
Have you had less interest in social activities or time with friends?	NO YES	MILD MODERATE SEVERE
Have you felt more irritable?	NO YES	MILD MODERATE SEVERE

Please indicate any **family** history of:

Condition		Family member
Strokes	YES NO	
Seizures	YES NO	
Alzheimer's disease or other type of dementia	YES NO	
High Blood Pressure	YES NO	
Heart Disease	YES NO	
Depression	YES NO	
Anxiety	YES NO	
Other Mental Health problems	YES NO	
Other serious medical conditions	YES NO	

Do you smoke cigarettes currently?	YES NO	_____ **Packs per day**
Have you smoked cigarettes in the past?	YES NO	_____ **Packs per day,** for _____ years **Year stopped:** _____
Do you drink alcohol currently?	YES NO	_____ **Drinks per week** (1 drink = 1 beer, or 1 glass of wine, or 1 mixed drink)
Have you used alcohol in the past?	YES NO	_____ **Drinks per day,** for _____ years **Year stopped:** _____ **Type of Alcohol:** _____
Do you use recreational drugs currently?	YES NO	**Explain:**
Have you used recreational drugs in the past?	YES NO	
Have you ever overused prescription medication to relieve pain or distress?	YES NO	

Do You:

Have problems with memory?	YES NO	MILD MODERATE SEVERE **Memory loss:** **Worsened gradually** YES NO **Began suddenly** YES NO **Occurs off & on** YES NO **Is worse at end of the day** YES NO
Have problems understanding what you read?	YES NO	MILD MODERATE SEVERE
Have problems understanding what other people say?	YES NO	MILD MODERATE SEVERE **Is this because of poor hearing?** NO YES SOME
Have changes in your handwriting?	YES NO	MILD MODERATE SEVERE
Have problems concentrating or paying attention?	YES NO	MILD MODERATE SEVERE
Have problems finding the "right" word when talking?	YES NO	MILD MODERATE SEVERE
Have problems remembering names?	YES NO	MILD MODERATE SEVERE
Have problems with math?	YES NO	MILD MODERATE SEVERE
Have problems with handling money?	YES NO	MILD MODERATE SEVERE
Have problems managing your finances?	YES NO	MILD MODERATE SEVERE

Do you need assistance with any of the following activities?

Activity	Never	Sometimes	Always
Cleaning house			
Preparing meals			
Paying bills			
Keeping track of medication			
Transportation (Driving)			
Bathing			
Dressing			
Walking			
Getting up and down			

SOCIAL INFORMATION

Marital Status: Married Single Divorced Widowed Co-habituating

# of marriages_____

City of Residence	Names of People living with you	Relationship to you

Names of children not living with you	Relationship	Place of residence

DEVELOPMENTAL HISTORY

Are you aware of any of the following?: (check all that apply)

____ Problems during prenatal development?

____ Exposure to drugs or alcohol prenatally?

Developmental delay in: ____Speech/language
____Motor Skills
____Physical Development
____Social Development

____ Serious childhood illness or injury?

Handedness: ☐ Right ☐ Left As a child, were you forced to change hands? YES NO

SCHOOL INFORMATION

Last school grade completed?_____ **Degrees Received**_____

How would you describe your grades? EXCELLENT AVERAGE POOR FAILING

If you left school before graduation, what was the reason?_____

List any special training or education:_____

Did you have any learning problems in school? YES NO

If yes, circle which were problem areas: READING WRITING MATH
BEHAVIORAL PAYING ATTENTION

Were you diagnosed with learning disabilities and/or ADHD? YES NO

If yes, did you receive any special help? YES NO

WORK HISTORY

Primary Occupation:_____

Are you retired? NO YES If yes, since when:_____

Type of retirement: VOLUNTARY MEDICAL

Current hobbies: _____

Are you disabled? NO YES If yes, since when:_____

What caused the disability?_____

Do you receive Social Security benefits? YES NO

Do you receive Private Disability benefits? YES NO

Please list your last several jobs:

Position	Employer	Approximate dates of employment

Did (or do) you serve in the military? YES NO

What branch? _____

How long? : Active: _____ Reserves: _____

Primary job responsibilities? _____

Were you exposed to combat situations? : YES NO

PSYCHOSOCIAL HISTORY

How would you describe your childhood?	**Circle all that apply:** HAPPY NORMAL DIFFICULT TROUBLED LONELY IDYLLIC CALM SAD FEARFUL DEPRIVED OTHER (PLEASE DESCRIBE):	
Have you ever experienced any traumatic events in your life?	NO YES	**If yes, circle all that apply:** DEATH OF PARENT OTHER DEATHS VERBAL ABUSE PHYSICAL ABUSE SEXUAL ABUSE FAMILY VIOLENCE CRIME VICTIM NEGLECT OTHER (PLEASE DESCRIBE):
List any other significant events in your childhood or later life: **Are there any other areas of concern?**		