Estes Neuropsychology

Demographic Information

Full Name:_____ Today's Date:_____

Date of Birth:_____ (M)_____ (F)_____

Street Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Is it OK to leave a message? Yes__ No__

Work Phone:_____ Is it OK to leave a message? Yes__ No__

Cell Phone:_____ Is it OK to leave a message? Yes__ No__

Referred by:_____

Primary care physician:_____ Phone:_____

Emergency Contact Person:_____ Phone:_____

Person Responsible for Payment:_____ Phone:_____

Address:_____

Signature of Person Responsible for Payment:_____

Primary Insurance Company:_____

Policy Holder's Name:_____ Date of Birth:_____

Secondary Insurance Company:_____

Policy Holder's Name:_____ Date of Birth:_____

CONSENT FOR EVALUATION

I, _____, understand that the purpose of this evaluation is to provide information about me to my physician or other health care provider who has requested the evaluation in order to assist in their diagnosis and treatment of me. The results will be gathered into a report by Dr. Estes that will be sent to my physician or other health care provider, and Dr. Estes may also discuss the results of the evaluation with them. If desired by me or my referring provider, Dr. Estes will also discuss the results with me and any others that I so designate by signing a release of information allowing Dr. Estes to do so.

There are occasions in which Dr. Estes may be required to release personal information or information that would otherwise be considered confidential. For example, Dr. Estes is required to notify authorities if he knows of or suspects that a child (or vulnerable adult) is being abused or if he has reason to believe that I may harm others or myself. Confidential information may also need to be disclosed because of a court order, medical emergency, or claim verification by third party payers such as insurance companies.

Dr. Estes' questions may touch on personal and private matters that could cause me emotional discomfort. I recognize that Dr. Estes has no intention of causing any personal discomfort, but that he is simply carrying out his professional task associated with this evaluation. I will cooperate to the best of my ability. I understand that although I am expected to give honest and accurate answers, I am free to refuse to answer any question I choose or to terminate the evaluation whenever I wish.

I understand that if fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information.

Background information and testing data are occasionally reviewed for research purposes, but I understand that my identifying information will not be disclosed to any outside sources.

I consent to evaluation and agreements with Estes Neuropsychology. I understand that I may revoke this consent in writing at any time. I also certify that I have been given the opportunity to read the HIPAA Notice Form for additional information regarding my clinical records and disclosures of protected health information.

_____ _____

Signature of client Date of Signature

_____ _____

Signature of client Guardian (if applicable) Date of Signature

ESTES NEUROPSYCHOLOGY

Consent for Release or Exchange of Confidential Information

I, _____ Date of Birth _____
First Last

Address_____ Zip Code _____

Authorize Estes Neuropsychology to exchange with/disclose to:

_____ _____
Name of individual or organization to which disclosure is made Telephone Number

_____ _____
Address Fax Number

The following information:

_____ Neuropsychological Evaluation
_____ Psychological Intake
_____ Diagnosis
_____ Progress Notes
_____ Recommendations
_____ Other _____

The purpose for disclose:
_____For treatment of client
_____To collaborate with treatment team
_____To comply with doctor referral
_____To comply with court order
_____Other_____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise specified in the regulations. I understand that this release also includes any reference to substance abuse treatment as protected by federal law. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken. This release will remain valid until either I request revocation, been terminated from this program or upon expiration in 60 days. I allow this authorization to remain in effect after the 60 days have expired as long as I am still being provided services and I have not revoked this request in writing. The receiving agency understands that it cannot re-release any of the confidential information received.

_____ _____
Signature of client Date of Signature

_____ _____
Signature of client Guardian (if applicable) Date of Signature