GINGER ARNOLD, PHD/ INTEGRATED NEUROPSYCHOLOGY, PC
30752 Southview Dr, Ste 130 Evergreen, CO 80439

PATIENT INFO

PATIENT NAME_____

ADDRESS_____

CITY, ST & ZIP_____

E-MAIL ADDRESS _____

PHONE NUMBER _____

OK TO LEAVE A MESSAGE? YES NO

DATE OF BIRTH_____ SEX ASSIGNED AT BIRTH: M F

PREFERRED PRONOUNS_____MARITAL STATUS_____

EMPLOYER NAME_____

INSURED/RESPONSIBLE PERSON INFO

NAME (if other than patient)_____

ADDRESS_____

CITY,ST & ZIP_____

E-MAIL ADDRESS _____

PHONE NUMBER_____

OK TO LEAVE A MESSAGE? YES NO

DATE OF BIRTH_____ SEX: M F

EMPLOYER NAME_____

EMERGENCY CONTACT/TELEPHONE #_____ RELATIONSHIP_____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME_____

INSURANCE ADDRESS_____

EMPLOYER NAME:_____

ID/POLICY NUMBER_____

GROUP NUMBER/NAME_____

INSURED/POLICY HOLDER NAME_____

INSURED/POLICY HOLDER DOB_____

SECONDARY INSURANCE INFORMATION

_____

_____

_____

_____

_____

_____

_____

WORK/AUTO CLAIM NAME OF CARRIER_____CLAIM#_____

CLAIM ADDRESS_____ PHONE #_____

ADJUSTER:_____ DOI_____ IN WHAT STATE DID ACCIDENT OCCUR?_____

REFERRING PHYSICIAN'S NAME & PHONE #_____

FINANCIAL POLICY

I am happy to bill your insurance for your visit if I accept your insurance plan. Payment is due at the time services are rendered if you do not have insurance. I accept cash, checks, and credit cards. Please be advised that ***you are responsible*** for paying for all services rendered if your insurance company refuses to pay for any reason. ***Returned checks and letters to you requiring certified mail will be subject to a $25 service charge added to your account.*** Charges may also be made for ***telephone calls, medical reports, medical records, and no shows. You will be charged the full session fee for appointments cancelled without 24-hour advanced notice.*** Please contact my billing office at 303 989 2086 if you have any questions regarding your account or your insurance.

ACKNOWLEDGEMENT OF FINANCIAL/RECORD RESPONSIBILITY: This information provided by me to Ginger Arnold, PhD is accurate and true to the best of my knowledge. I understand that I am responsible and agree to pay for services rendered, including reasonable attorney's fees and 100% costs of collection in the event of default. I also hereby authorize Ginger Arnold, PhD/Integrated Neuropsychology, PC and employees to furnish or obtain any/all information to/from insurance carriers/Social Security Administration (Medicare), the referring doctor or PCP, other physicians or agencies to whom we refer, or designated next of kin or caregiver concerning my illness and treatments. I authorize my insurance company to send payment directly to Integrated Neuropsychology, PC/Ginger Arnold, PhD.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY:_____ Date:_____

GINGER ARNOLD, PHD/ INTEGRATED NEUROPSYCHOLOGY, PC
30752 Southview Dr, Ste 130 Evergreen, CO 80439
445 Union Blvd, Ste 301, Lakewood, CO 80228

Colorado Patient Rights Information / HIPAA Acknowledgment

The State of Colorado mandates that patients be given the following additional information at the start of psychological care:

Dr. Arnold's credentials:
Degree: PhD in Clinical Psychology from the Fuller Graduate School of Psychology, 2002
Internship in Clinical Psychology at Kaiser Permanente Los Angeles Department of Psychiatry, 2001-2002
Post-Doctoral Fellowship in Neuropsychology at Harbor UCLA Medical Center, 2002-2004
License: Colorado License for the Independent Practice of Psychology, #3900

The practice of psychologists is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

As to the regulatory requirements applicable to mental health professionals: **A Licensed Psychologist must hold a doctorate degree in psychology and have at least one year of post-doctoral supervision.** [A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is *not* licensed or certified, and no degree, training or experience is required. A licensed Psychiatrist must hold a medical or osteopathic degree, and have completed a one year internship and a residency in psychiatry.]

Neuropsychological and psychological assessment involves an interview and tests and procedures that assess functioning in various domains such as attention, concentration, language skills, visuospatial skills, motor coordination, memory, complex thinking, mood, and personality functioning. These require people to put forth their best effort in order to accurately reflect their current functioning.

You are entitled by law to receive information about methods of assessment and treatment, the nature of any clinical techniques used, the duration of planned care (if known), and your doctor's fee schedule. You may always seek a second opinion, and you may terminate any elective treatment with any practitioner at any time.

In a relationship with any health care professional, such as with a psychologist, physician, etc., sexual intimacy is never appropriate and should be reported to the individual's respective licensing, registration or certification board

Your communications with a psychologist are confidential, although *you should be aware that rare exceptions exist under certain conditions.* These are described in the more extensive information form provided for you and detailed in the HIPAA Notice of Privacy Rights). Some of these exceptions are listed in Section 12-43-218 and the Notice of Privacy Rights you were provided, and there are other exceptions in Colorado and Federal law. For example, psychologists are required to report child abuse to authorities. If possible, you will be informed if such a rare legal exception arises during assessment or therapy.

I have read the preceding information, which has also been provided verbally, and I understand my rights as a patient or as the patient's legally responsible party**.**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE HAD THE OPPORTUNITY TO READ THIS FORM AND AGREE TO ITS TERMS. THIS ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE PATIENT SERVICES AGREEMENT AND THE HIPAA NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.

Signature_____ Date_____

Printed Name: _____

Person Signing for Patient, If Any _____ Date_____

Relationship to the Patient _____

I am the legal guardian or conservator appointed by the Court for this patient **[ ] Yes [ ] No**

GINGER ARNOLD, PHD/ INTEGRATED NEUROPSYCHOLOGY, PC
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Authorization for Release of Records

This form authorizes Dr. Arnold/Integrated Neuropsychology, PC to release and exchange protected health information from your clinical record to people specifically designated by you.

Patient Name_____ DOB_____

I authorize Dr. Ginger Arnold/Integrated Neuropsychology, PC, and/or her assistant, who handles the release of her records, to release and/or exchange information about my neuropsychological or psychological history, conditions, test results, examinations, and status. This may include information regarding my drug and alcohol history, mental health treatment and conditions, and/or HIV/AIDS or Huntington's disease status.

This information may be released to and exchanged with the following doctors, hospitals and/or others:

___ Referring doctor:_____

Doctor's phone number: _____ Doctor's fax number: _____

___ PCP:_____

PCP's phone number: _____ PCP's fax number: _____

___ Other:_____

Phone number: _____ Fax number: _____

___ Other:_____

Phone number: _____ Fax number: _____

I am authorizing release and exchange of this information *at my request* and of my own free will. This authorization shall remain in effect: *until I withdraw my permission to release and exchange this information in writing*, or other: _____

I have the right to revoke this authorization, in writing, at any time by sending written notification to Dr. Arnold. However, my revocation will not be effective to the extent that Dr. Arnold/Integrated Neuropsychology, PC has already taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that a psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Authorized Representative Date

A description of such representative's authority legally to act for the patient must be provided if the authorization is signed by a personal representative of the patient

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445 Union Blvd, Ste 301, Lakewood, CO 80228
Phone: (303) 989 2086 Fax: (720) 259 7298

Thank you for taking the time to complete this history! It will ensure that I obtain more accurate information. It will also allow us to discuss more important issues to you during your time with me.

Why are you seeking a neuropsychological assessment?

What do you hope to learn from your assessment/What questions would you like for me to answer?

Who originally suggested that you have this evaluation?

Are you seeking disability? [ ] yes [ ] no [ ] unsure
Are you seeking workers' compensation? [ ] yes [ ] no [ ] unsure
Is your condition a result of an accident or injury? [ ] yes [ ] no [ ] unsure
If yes, date of injury: _____
Are you involved in any lawsuits? [ ] Yes [ ] No
Did your attorney ask you to get this examination or evaluation? [ ] Yes [ ] No
Your attorney's name and firm, if any: _____

History of Present Illness or Problem
Do you feel you have memory or thinking problems? [ ] Yes [ ] No
Do people tell you that you have memory or thinking problems? [ ] Yes [ ] No
Please indicate the very first month and year[_____/_____] you or someone else began to notice your memory, thinking, or speech problems.

With Regard to your memory or thinking problems:
Did they come on [ ] all at once or [ ] slowly/gradually or [ ] N/A
Have they [ ] stayed about the same [ ] become gradually worse or [ ] N/A
If they have become worse over time, has this change been [ ] fast [ ] slow/gradual [ ] step-wise
Are they [ ] sometimes better and sometimes worse [ ] the same day-to-day or [ ] N/A
If they fluctuate, do they [ ] change throughout the day [ ] seem worse at night [ ] Change from day-to-day
Do you think you are ever able to function at your earlier, 100% best? [ ] Yes [ ]No [ ] Not sure

Do people who know you well feel that your personality has changed and that you are behaving differently than you used to behave? [ ] Yes [ ] No [ ] Not sure If **yes**, please circle any of the following changes that have been noticed:

Anger outbursts	Irritability	Crying
Moodiness	Lack of Motivation	Other
Sadness	Impulsivity	
Anxiety	Lack of Interest	

Please check all of the following problems you are currently having:
____**Attention & Concentration Problems**
____ I get distracted more easily now than I did before.
____ I have a hard time focusing on conversations, what I read, television programs, etc.
____ I get lost in the middle of conversations.
____ I space out at times and lose track of what is going on around me.
____ Other:

____**Speed of Thinking**
____ I am thinking more slowly than I used to think.
____ I can't think fast enough to follow what people are saying to me.
____ I am responding much more slowly than I used to respond.
____ I am thinking much faster than I used to think.
____**Memory Problems**
____I am more forgetful, such as of where I put things.
____ I am forgetting people's names more often.
____I now have to write things down in order to remember them, and I didn't have to do this before.
____I forget conversations I have had, and I wouldn't have before.
____ I lose my train of thought while I am speaking and forget what I meant to say.
____People tell me that I repeat stories or questions.
____I have forgotten periods of time from my life.
____I have trouble remembering words I want to say when I am speaking.
____I forget what I was about to do.
____ I can't remember people's faces
____I have trouble remembering procedures I have done many times.
____Other:
____Speech & Language Problems
____I have more trouble speaking clearly.
____I have more trouble thinking of the words I want to say.
____I have more difficulty saying the right word even though I know what I want to say.
____I say the wrong words by accident instead of the words I meant to say.
____I have more difficulty understanding what I read or what people say.
____I have more difficulty writing as clearly or as well as I did before.
____I have had periods in which I speak gibberish and make no sense.
____Other:
____Perceptual Problems
____I can't see as clearly or as well.
____I can't hear as clearly or as well.
____I see things that I know, or other people tell me, are not there.
____I have gotten lost, or had trouble finding my way around, while driving or walking around familiar places.
____I have trouble figuring out directions or distinguishing between left and right.
____Other:
____Complex Thinking Problems
____I am not as organized as I used to be.
____I can't multitask anymore.
____I get confused about what I am doing.
____It takes me a lot longer to complete tasks.
____I have more difficulty making plans
____I have more trouble figuring out the proper order of steps to complete tasks.
____I have more trouble with numbers, figures, and arithmetic.
____I make mistakes when I try to pay bills or balance my checkbook.
____I get confused while cooking.
____I can't keep track of my medications and remember to take them when prescribed.
____Other:
____Physical Problems
____My sense of smell has diminished.
____My sense of taste has changed or diminished.
____I have tremors.
____I cannot feel things as well.
____I am less coordinated.
____I am having trouble walking.
____I have balance problems.
____I have fallen _____ times in the past _____ year(s)

_____Driving:

[ ] I am driving [ ] I stopped driving _____ (date)

____I have had, and am having, no problems driving at all.
____I have had a ticket, accident, or fender bender in the past year.
____I feel completely safe driving and my family and friends agree with me about this.
____I feel completely safe driving, but my family or doctor does not think it is safe for me to drive.

____Sleep

____I have trouble getting to sleep.
____I have trouble staying asleep.
____I can't get back to sleep when I wake up to use the restroom.
____I wake up too early.
____I don't feel rested or rejuvenated after sleep, and I feel sleepy during the day.
____I take _____ naps per day.
____I sleep too much.
____I have nightmares or very vivid dreams.
____I talk or walk in my sleep.
____I have been told or suspect that I act out my dreams while asleep(i.e., flailing my arms, punching, etc.)
____I have had a sleep study done at some time in the past.
____People sometimes tell me I stop breathing when I'm asleep for short times
____I snore.
____Sometimes I awaken myself snoring or gasping.
____My legs or body move around during the night when I am sleeping or trying to sleep.
____I have been prescribed CPAP, BiPAP, ViPap or some other sleep device: [ ] Yes [ ]No

IF YES:

____ I never got it set up.
____I am unable to tolerate it and cannot use it
____I use it about 1-3 hours a night.
____I use it between 3-6 hours a night.
____I use it throughout the entire night.
____I use it once or twice a month.
____I use it once or twice a week.
____I use it 4-5 times a week.
____I use it every night

Please check all that apply:

____Head injury
____Brain infection (such as encephalitis)
____Exposure to toxic substances such as chemicals or lead
____Complications with your birth
____Vitamin or mineral deficiencies
____Seizures or epilepsy
____Stroke, TIA, or subdural bleed
____Brain aneurysm
____Parkinson's disease
____Tremor
____Regular headaches or migraines
____Dementia/Alzheimer's Disease
____Multiple sclerosis
____chronic pain
____Cancer
____Hypertension/high blood pressure
____High Cholesterol
____Thyroid disease
____Diabetes
____Asthma/Breathing problems
____Sleep apnea
____Heart disease
____Atrial fibrillation or flutter
____Heart attack or heart failure
____COPD

Please list family member

___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member **Type:**
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member
___me ___family member

____Liver disease	___me ___family member
____Kidney disease	___me ___family member
____Autoimmune disease	___me ___family member **Type:**
____HIV/AIDS	___me ___family member
____Restless leg syndrome	___me ___family member
____Negative reactions to anesthesia	

Please list all the **surgeries** you have had and the year you had them:

Are you having any **problematic/unpleasant side effects to any medications**? [ ] Yes [ ] No [ ] Unsure
Are there any **other accidents**, **surgeries**, or **medical problems** you have had or suffered from? If so please list them. Please continue on the back of this page if necessary.

Which of these kinds of specialists have you ever seen? Check all that apply even if you aren't sure:

___Neurologist	___Endocrinologist (for diabetes or thyroid)
___Neurosurgeon	___Transplant doctor
___Psychiatrist	___Nephrologist (kidney doctor)
___Clinical Psychologist for counseling	___Hepatologist (liver doctor)
___Neuropsychologist for memory/cognitive testing	___Oncologist (cancer doctor)
___Mental health or substance abuse counselor	___Rheumatologist
___Pain specialist	___Homeopath
___Sleep doctor	___Chiropractor
___Physiatrist (rehabilitation doctor)	___Speech therapist
___Cardiologist (heart doctor)	___Other:

Family Medical History:
Are you adopted? [ ] Yes [ ] No

Please list any major medical disorders your **mother** has/had:

If your mother is deceased, please indicate her age at death _____
What was her cause of death?

Please list any major medical disorders your **father** has/had:

If your father is deceased, please indicate his age at death _____
What was his cause of death?

Please list the number of **brothers** you have ____ Please list the number of **sisters** you have ____
Please list which ones have which medical disorders (if any)

Are any deceased? If yes, please list their ages and the causes of death:

Please list the number of children you have _____Please list their ages
Please list any medical disorders they have

Are any deceased? If yes, please list their ages of death and the causes of death:

Please list all the sources of stress in your life at this time or since your symptoms began:

Mood and Other Symptoms: Please check any and all that apply:

____I generally feel happy most of the time.
____I have the normal mix of good days and bad days that most people have.
____I don't seem to feel much, good or bad.
____It is hard for me to realize when I am stressed or upset.
____I feel sad or depressed most of the day, most days.
____I am crying more often.
____I feel hopeless.
____I have thoughts of suicide and sometimes I am afraid I might act on them.
____I have thoughts of suicide but know I would never act on them.
____I feel guilty about many things.
____I don't feel as interested in or get as much pleasure from things and people as before.
____I don't feel like doing anything and have difficulty motivating myself.
____I am avoiding people and social events.
____I am having more difficulty making decisions.
____My sleep has changed. [ ] I am sleeping more than usual. [ ] I can't sleep as well as usual.
____My appetite has changed. [ ] I am eating more than I used to eat. [ ] I don't feel like eating much.
____My weight has changed. [ ] My weight has increased. [ ] My weight has decreased.
____ I feel restless much of the time.
____ I am more irritable.
____ I have moments when I get panicky all of a sudden.
____ I feel anxious or nervous [ ] often [ ] nearly all the time.
____ I have panic attacks
____ I am terrified of certain things, such as heights, needles, or something else I try to avoid if at all possible.
____ Sometimes I have to say, think or do special things to prevent bad things from happening.
____ I can't stop thinking about certain things.
____ I have behaviors or actions I think are (or others have called) "obsessive," "compulsive," or "OCD"
____ Sometimes I hear things other people do not hear (sounds, voices, music, etc.)
____ Sometimes I see things other people do not see.
____ Sometimes I taste or smell things other people don't.
____ Sometimes I feel that people are out to get me.
____ I have mood swings that last more than a few hours or a day.
If yes, [ ] my mood swings are quick and sudden, or [ ] slow and gradual
____ I have worried I might be "bipolar" or "manic depressive" or someone else has told me that they think I am.
____ Sometimes I feel so good or "up" that I go days without sleep, or with very little sleep.
____ My mind sometimes races extremely fast, or jumps from one thing to another thing very quickly.
____ Sometimes I have trouble controlling my impulses, which can get me into trouble.
____ Sometimes my speech becomes really fast and pressured for days at a time.
____ I sometimes have angry outbursts.
____ My anger outbursts are only verbal (yelling, saying angry things).
____ Sometimes my anger outbursts are physical (throwing, hitting, etc.).
____ Sometimes I get so angry that I worry I could possibly hurt or injure someone if things got out of hand.
____ Sometimes things around me don't feel real, even though I know they are.
____ Sometimes I feel disconnected from or 'out of sync' with my body.
____ I have moments when I seem unaware of what is going on around me; when I seem to "click off."

Have you or a relative suffered from any of the following?

Depression	___me ___family member
Anxiety	___me ___family member
Bipolar disorder /manic depression	___me ___family member
Schizophrenia	___me ___family member
Attention Deficit Disorder	___me ___family member
Post-Traumatic Stress Disorder	___me ___family member
Alcohol or drug problem	___me ___family member
Suicide attempt(s)	___me ___family member
Psychiatric hospital stay(s)	___me ___family member

Personal Habits:

Caffeine: How much caffeine do you take in every day?
_____cups of coffee _____cups of tea _____caffeinated sodas/colas _____other

Sugar: Do you consume products with sugar in them?
Please indicate how many of these you consume per day:
____beverages ____processed foods ____ candy ____cookies ____ other desserts ____ Other:

Tobacco: Did you ever smoke? **[ ] Yes [ ] No** If yes, for how many years?_____
How much do/did you smoke per day? _____
Have you quit smoking? **[ ] Yes [ ] No** When did you quit?_____
Do/did you chew tobacco? **[ ] Yes [ ] No** If yes, how much per week? _____

Alcohol: How many alcoholic beverages do you have *on an average per day*?
[ ] more than 24 [ ] 13-24 [ ] 9-12 [ ] 5-8 [ ] 3-4 [ ] 1-2 [ ] None
If you drank *in the past but not now*, how many drinks did you have *on your average day*?
[ ] more than 24 [ ] 13-24 [ ] 9-12 [ ] 5-8 [ ] 3-4 [ ] 1-2
On your *heaviest* day of drinking in the past year, how many drinks did you have?
[ ] more than 24 [ ] 13-24 [ ] 9-12 [ ] 5-8 [ ] 3-4 [ ] 1-2
On your *heaviest* day of drinking during your life, how many drinks did you have?
[ ] more than 24 [ ] 13-24 [ ] 9-12 [ ] 5-8 [ ] 3-4 [ ] 1-2
What kind of beverages do/did you drink? [ ] beer [ ] wine [ ] mixed drinks [ ] hard liquor
Have you ever had a DUI or DWAI? [**] Yes [ ] No**
If yes, how many times? _____when? _____
Have you ever attended AA or any other alcohol treatment program? **[ ] Yes [ ]No**

Other: Which of the following substances have you used or do you currently use?
Current/Now In the past
[ ] marijuana/pot **[ ] yes [ ] no**
[ ] cocaine **[ ] yes [ ] no**
[ ] heroin **[ ] yes [ ] no**
[ ] methamphetamine/uppers/speed **[ ] yes [ ] no**
[ ] MDMA – ecstasy –"Molly" **[ ] yes [ ] no**
[ ] hallucinogens/LSD/mushrooms **[ ] yes [ ] no**
[ ] IV drugs of any kind - "needles" **[ ] yes [ ] no**
[ ] other: _____
Have you ever been ***treated*** *for* an alcohol or drug use problem? [ ] yes [ ] no
Have ***you*** ever worried you might have had an alcohol or drug use problem? [ ] yes [ ] no
Has ***anyone else*** ever told you they felt you had a drug or alcohol use problem? [ ] yes [ ] no
Have you ever had a problem with prescription drugs or an addiction to them? [ ] yes [ ]no

Social History
How would you describe your childhood overall and in general?
___Easy and happy ___Sad, hard, or painful ___Other:
Did you experience any of the following?
____Neglect
____Emotional abuse [ ] in childhood [ ] in adulthood
____Sexual abuse or rape in childhood [ ] in childhood [ ] in adulthood
____Physical abuse or beatings [ ] in childhood [ ] in adulthood
____Assault [ ] in childhood [ ] in adulthood
____Other traumatic experiences
Do you ever have unwanted memories, thoughts or feelings about any of the above? [ ] Yes [ ] No [ ] N/A
Do you have nightmares about any of the above? [ ] Yes [ ] No [ ] N/A

History of Cognitive Functioning:
Did you suffer any problems or delays as a child in learning to
[ ] walk, [ ] talk, [ ] read, [ ] write, [ ] None of these
Did you suffer from a learning disability or problems learning in any subjects?
___Yes ___No ___Unsure If so, please describe:
Did you have problems paying attention? **___Yes ___No**
Were you ever in special education or tutoring? **___Yes ___No**
Were you ever [ ] held back, or [ ] jumped ahead a grade? **___Yes ___No**
Do you speak any languages other than English? **___Yes ___No**
What is your *primary* (or *first* spoken) language? _____
What kind of student were you overall: **[ ] good [ ] poor [ ] average**
I usually earned or received grades in the **A B C D F** range, overall.
____ I was not a very good student but I could have been.
____ School was hard for me even though I tried and worked hard.
Check all that apply:
____ I dropped out of school but *finished* the _____grade.
____ I earned my GED
____ I graduated from high school
____ I completed ____ years of college at _____
____ I completed ____ years of [ ] trade or [ ] business school at_____
____ I earned the following degrees_____

Work History:
What jobs have you held, including being a homemaker or stay-at-home parent?

Do you work at the present time? **[ ] Yes [ ] No [ ] Does Not Apply**
If so, are your cognitive or memory problems affecting your work or schoolwork? **[ ] Yes [ ] No or [ ] Does Not Apply**
Are you on disability? **___Yes ___No** If yes, [ ] medical [ ] psychiatric
Are you retired? **___Yes ___No** If yes, what year?_____

Did you serve in the military? **___Yes ___No**
If so, which branch? [ ] USA [ ] USN [ ]USMC [ ] USAF [ ] Coast Guard
If so, did you ever see active duty / combat? **___Yes ___No**
If so, what kind of discharge did you receive? ___Honorable ___General ___Other
If so, do you have any service connected disability? **____Yes ____No _____%**

Have you ever been arrested or convicted of a crime other than a minor (non-DUI) traffic offense, or done any time in jail, prison or juvenile detention? **[ ] Yes [ ] No**

Social Interactions:
Are you married or in an intimate partner relationship at this time? **___Yes ___No**
If married or in a committed partner relationship now, for how long?_____
Have you been married before? **[ ] Yes [ ] No [ ] If yes, how many times before?_____**
With whom do you currently live? _____

How would you describe your social support and friendship network of people in your life?
____ I have many close friends
____ I have a few close friends
____ I don't have any friends I'm close to
____ I have acquaintances I see on occasion
____ I keep pretty much to myself'
Who is a source of support for you?

How often do you see friends and family?

Do you participate in any groups? **[ ] Yes [ ] No**
Do you volunteer? **[ ] Yes [ ] No**
Is *religion or spirituality* an important part of your life **[ ] Yes [ ] No**

What religion do you practice?

How often do you exercise?

What do you do for exercise?

What activities do you enjoy?

Have your symptoms caused you to stop doing things you enjoy? **[ ] Yes [ ] No**

What questions do you hope I will answer with this evaluation?

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MEDICATION LIST

Date: _____

Patient Name: _____Date of Birth: _____

Please write in all ***prescription medications***, ***over-the-counter medications,*** and ***supplements*** you are taking. Please write the dosage, the number of times you take it per day, and how it is taken (i.e. orally, injection, etc).

Medication Name	Dosage	Times per day	How taken (orally, etc.)	Taking as prescribed?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

GINGER ARNOLD, PHD
Integrated Neuropsychology, PC
30752 Southview Dr, Suite 130, Evergreen, CO 80439
445 Union Blvd, Ste 301, Lakewood, CO 80228
Phone: (303) 989 2086
Medical Record Fax: (720) 259 7298
Referral Fax: (720) 441 0480

PATIENT SERVICES AGREEMENT
AND
HIPPA NOTICE OF PRIVACY PRACTICES

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

NEUROPSYCHOLOGICAL SERVICES
Neuropsychological assessment is an evaluation of how people's brains are functioning and affecting their behavior and mood. It involves a clinical interview about symptoms, general functioning, medical and psychological history, as well as educational and occupational history. It also includes a neurobehavioral examination and tests of attention, thinking speed, language skills, visuospatial skills, visual and verbal memory, motor functioning, complex thinking, and mood. Such an evaluation requires your full cooperation and best effort in order for me to obtain an accurate assessment of your true abilities. The evaluation takes a number of hours. After the assessment is complete, I will score and analyze your performance and write up the results in a report. This report will be sent to the clinician who referred you for the assessment. I will schedule a time to meet with you to review the results and make recommendations for treatment or follow-up. I encourage you to bring family members, partners or friends with you who can help you implement my recommendations.

CONTACTING ME
Due to my work schedule, I am often not immediately available by telephone because I do not answer the phone when I am with a patient. For questions about insurance and billing, general business matters, scheduling and requests for records please call (**303) 989 2086** and speak with Laura McGinley. You can also leave a message for me at that number if you have a question that only I can answer. I will return your call as soon as I am able. If you are difficult to reach, please state some times when I might reach you. Please understand that it may not always be possible for me to return your call the same day.

If it is after regular business hours and you have an *emergency*, you may reach me at 720 737 8428. If you cannot reach me and cannot wait for me to return your call, immediately call 911 or go to the nearest emergency room. If I am

unreachable for a longer period of time, information regarding the psychologist covering my practice in my absence will be provided by Laura and on my voicemail.

SERVICE/EMOTIONAL SUPPORT ANIMALS

You are welcome to bring your service/emotional support animal to my office as long as the animal sits on the floor next to you, does not cause any disturbance, and does not approach or harm anyone. You are required to clean up after your animal and pay all cleaning and repair costs if it soils or destroys anything in the office suite.

PROFESSIONAL FEES

My hourly fee for neuropsychological assessment is $200.00 per hour. This includes the interview, testing, interpretation, report writing time and feedback session. In addition to the initial examination, I also charge this amount for other professional services you may need. I pro-rate the hourly cost if I work for periods of less than one hour. Other services may include additional report or letter writing, completing disability paperwork, preparation of records or treatment summaries, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if I am called to testify by another party. I currently charge $350.00 per hour for review of records and speaking with an attorney. I charge $500 per hour to do testimonies in court.

BILLING AND PAYMENTS

I am happy to bill your insurance for your sessions if I accept your insurance plan. Payment is due at the time services are rendered if you do not have insurance. I accept cash, checks, and credit cards. Please be advised that ***you are responsible for paying for all services rendered if your insurance company refuses to pay for any reason. Returned checks and letters to you requiring certified mail will be subject to a $25 service charge added to your account.*** Payment schedules for other professional services will be agreed to when they are requested. I am often agreeable to negotiating a payment installment plan in circumstances of unusual financial hardship. I have the option of using legal means to secure the payment if your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. ***You are also responsible for any attorney's fees and 100% costs of collection in the event of default.***

COPIES OF YOUR REPORT

One copy of your report will be provided to you free of charge. You will be charged for all costs and for the time it takes for me to resend, fax, mail or otherwise provide you with additional copies of misplaced reports.

LIMITS ON CONFIDENTIALITY

Uses and Disclosures Requiring Authorization

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- *Professional Consultation* - I may occasionally consult other health and mental health professionals, making every effort to avoid revealing identifying information. *The other professionals are also legally bound to keep the information confidential.* I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- *Collaborative Care* - I may discuss your case and test results with your referring physician, and I will provide them with my report on the results of your assessment.

- *Administration* - I employ Laura McGinley to handle scheduling, billing, sending and receiving records, and quality assurance. I need to share protected information with her for both clinical and administrative purposes. She is bound by these same rules of confidentiality and has been trained in how to protect your privacy.

  As required by HIPPA, I have a formal business associate contract with Laura McGinley in which she agrees to maintain the confidentiality of patient data except as specifically allowed in the contract or otherwise required by law. If you desire, I can provide you with a blank copy of this contract.

- *Billing Insurance* - I may disclose information to obtain reimbursement or health care services. For instance, if your insurance is covering this evaluation, it will require release of your protected health information in order to determine eligibility and benefits or to provide reimbursement. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. You always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract such as Medicare patient status].

Uses and Disclosures Without Consent or Authorization

There are some situations where I am permitted or required to disclose information without either your consent or Authorization. If such situations arise, I will make every effort to discuss it with you before taking any action, and I will limit my disclosure to what is necessary. Such circumstances include:

- *Threat to Self* - If you threaten to harm yourself, I may be obligated to seek hospitalization for you, or to contact family members or others who can help provide protection.

- *Threat to Others* - If you communicate a serious threat of imminent physical violence against specific people, I must make an effort to notify such people; and/or notify an appropriate law enforcement agency; and/or take other appropriate action including seeking hospitalization for you.

- *Child Abuse* - If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect or if I have observed a child being subjected to circumstances or conditions which would reasonably result in abuse or neglect, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.

- *Abuse of Dependent Adult* - If I have reasonable cause to believe that an at-risk adult has been or is at imminent risk of being mistreated, self-neglected, or financially exploited, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. *If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.*

- *Health Oversight Activities* – If the Colorado State Board of Psychologist Examiners or an authorized professional review committee is reviewing my services, I may disclose your information that board or committee.

- *Filed Complaints and Lawsuits* - If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself.

- *Workers Compensation* - If you file a workers compensation claim, I am required to submit a report to the Workers Compensation Division.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking assessment or therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others [or where information has been supplied to me by others confidentially, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most situations, I am allowed to charge a copying fee per page (and for certain other expenses). If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon request.

I also keep a set of what is legally called Psychotherapy Notes. These can be made during a testing examination or an actual therapy session. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from patient to patient, they can include the contents of our conversations or sessions, my analysis of those conversations, and how they impact on your therapy or evaluation. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record [as well as information that has been supplied to me confidentially by others]. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Records are maintained for 7 Years following termination of treatment

Statute of limitations for complaints regarding record maintenance:

- Any person who *alleges that a mental health professional has violated the licensing laws related to the maintenance of records* of a client eighteen years of age or older ***must file a complaint*** or other notice with the licensing board ***within seven years*** *after the person discovered or reasonably should have discovered this.* Pursuant to law, ***this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of the last contact with the client, whichever is later.***

- ***When the client is a minor*** the records must be retained for ***seven years*** commencing either upon the last day of treatment ***or when the child reaches eighteen years of age, whichever comes later,*** but ***in no event shall records be kept for more than twelve years.***

PATIENT RIGHTS

- HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of protected health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send correspondence to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of your protected health information in my mental health and billing records used to make decisions about you for as long as your protected health information is maintained in the record. This does not include a right to inspect test record forms or certain other testing materials, which are protected under copyright law and trade secret legislation. I may deny your access to protected health information under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of your record for as long as the protected health information is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of your information. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

MINORS & PARENTS
Although I do not regularly conduct a pediatric or adolescent practice, patients should be aware of the following general information:

Patients under 15 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records, unless I decide that such access is likely to injure the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will attempt to discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

QUESTIONS AND COMPLAINTS
If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me, Dr. Arnold, at **(303) 989 2086**. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Ginger Arnold, Ph.D. at 30752 Southview Dr, Ste 130, Evergreen, CO 80439.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION:

Signature_____ Date_____

Printed Name: _____

Person Signing for Patient, If Any _____ Date_____

Relationship to the Patient _____

I am the legal guardian or conservator appointed by the Court for this patient **[ ] Yes [ ] No**