

Savannah Neuropsychology

ADULT BIOGRAPHICAL INFORMATION SHEET

DATE FORM COMPLETED: _____ COMPLETED BY: _____

PATIENT NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

RACE/ETHNICITY: _____ ARE YOU DRIVING: _____

HANDEDNESS (Circle One): RIGHT LEFT AMBIDEXTROUS

WHERE DID YOU GROW UP? _____

MARITAL STATUS (Circle One):

Never Married Married Significant Other Divorced Separated Widowed

NUMBER OF MARRIAGES: _____

NUMBER OF CHILDREN: _____ AGES OF YOUR CHILDREN: _____

EMERGENCY CONTACT: _____ PHONE: _____

FAMILY HISTORY

FATHER'S AGE: _____ IF DECEASED, CAUSE OF DEATH: _____

MOTHER'S AGE: _____ IF DECEASED, CAUSE OF DEATH: _____

NUMBER OF LIVING BROTHERS: _____ THEIR AGES: _____

NUMBER OF LIVING SISTERS: _____ THEIR AGES: _____

NUMBER OF DECEASED SIBLINGS: _____ CAUSE OF DEATH: _____

EDUCATIONAL HISTORY

HIGHEST GRADE COMPLETED: _____ IF STILL IN SCHOOL, GRADE: _____

Circle all that apply:

HIGH SCHOOL DIPLOMA GED ASSOCIATES BACHELORS MASTERS DOCTORATE

COLLEGE ATTENDED: _____ DEGREE OBTAINED: _____

VOCATIONAL TRAINING, if applicable: _____

AREA OF SPECIALIZATION: _____

EMPLOYMENT HISTORY

PRESENT EMPLOYER: _____

JOB TITLE/POSITION HELD: _____

LENGTH OF EMPLOYMENT: _____

PREVIOUS EMPLOYMENT: _____

JOB TITLE/POSITION HELD: _____

MEDICAL HISTORY

CURRENT DOCTORS: _____

GENERAL PHYSICAL HEALTH AT PRESENT: (Circle one):

VERY GOOD

GOOD

OKAY

POOR

VERY POOR

DATE OF LAST GENERAL PHYSICAL EXAM: _____

DATE OF LAST HEARING SCREENING/EXAM: _____

DATE OF LAST VISION SCREENING/EXAM: _____

CURRENT MEDICATIONS/TREATMENTS: (You may attach a list if you prefer.)

DRUG/TX: _____ PURPOSE: _____ PRESCRIBING MD: _____

DRUG/TX: _____ PURPOSE: _____ PRESCRIBING MD: _____

DRUG/TX: _____ PURPOSE: _____ PRESCRIBING MD: _____

DRUG/TX: _____ PURPOSE: _____ PRESCRIBING MD: _____

DRUG/TX: _____ PURPOSE: _____ PRESCRIBING MD: _____

DRUG/TX: _____ PURPOSE: _____ PRESCRIBING MD: _____

PAST ACCIDENT/INJURIES: (You may attach a list if you prefer.)

TYPE OF ACCIDENT/INJURY: _____ DATE: _____

WORKER'S COMP: YES [] NO []

TYPE OF ACCIDENT/INJURY: _____ DATE: _____

WORKER'S COMP: YES [] NO []

TYPE OF ACCIDENT/INJURY: _____ DATE: _____

WORKER'S COMP: YES [] NO []

PAST SURGERIES: (You may attach a list if you prefer.)

TYPE OF SURGERY: _____ DATE: _____

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TYPE OF SURGERY: _____ DATE: _____

TYPE OF SURGERY: _____ DATE: _____

MEDICAL DISORDERS HISTORY: (Check all that apply)**CARDIOVASCULAR:**

	PATIENT	FAMILY
Heart Attack		
Heart Disease		
Chest Pain/Angina		
Blocked Arteries		
By-Pass Surgery/Angioplasty		
High Blood Pressure/Hypertension		
Heartbeat Irregularities		

GASTRO/INTESTINAL:

	PATIENT	FAMILY
Chronic Stomach/Intestinal Distress		
Ulcer(s)		
Diverticulitis		
Cancer (Stomach, Colon)		

MULTI-SYSTEMS:

	PATIENT	FAMILY
Diabetes		
Renal/Kidney Disease		

	PATIENT	FAMILY
Rheumatoid Disease		
Sickle Cell		
Glandular Disorder (Thyroid, Hormonal)		
Reproductive System Disorder		
Sexually Transmitted Disease		
HIV/AIDS		
Cancer		
Autoimmune Disorder		
Covid		

NEUROLOGICAL DISORDERS:

	PATIENT	FAMILY
Open/Closed Head Injury		
Senility		
Movement Disorders		
Seizures/Blackouts		
Sleep Disorder (Apnea, etc.)		
Encephalitis		
Brain Tumor		
Headaches		
Stroke/Pin-stroke(s)		
Memory Problems		
Fibromyalgia		
Multiple Sclerosis		
Learning/Developmental Disorders		
Attention Deficit Disorder		

ORTHOPEDIC DISORDERS:

	PATIENT	FAMILY
Fractures		
Dislocations		
Spinal Disorder(s)		
Long Term Pain		
Bone Cancer		
Arthritis		
Carpel Tunnel		
Disc Disease		

PSYCHOLOGICAL/PSYCHIATRIC DISORDERS:

	PATIENT	FAMILY
Mood Disorder (e.g. Depression)		
Anxiety Disorder (e.g., Anxiety, Panic, Phobia, etc.)		
Psychotic Episodes		
Alcohol Excess/Abuse		
Prescription Drug Abuse/Dependency		
Non-prescription Drug Abuse/Dependency		
Nervous Breakdown		

ANY OTHER DISORDERS OR ILLNESSES:

PSYCHIATRIC TREATMENT AND/OR PSYCHOLOGICAL COUNSELING HISTORY:

CURRENT HISTORY (With Whom): _____
Length of Treatment: _____

PREVIOUS HISTORY (With Whom): _____
Length of Treatment: _____

Have you ever received INPATIENT psychiatric treatment? Yes [☐] No [☐]
If yes, when/where: _____

Are you planning to use the results of this evaluation for work/school accommodations, disability benefits, or current or future court cases?

(Circle one): Yes No If yes, please elaborate: _____

OTHER INFORMATION YOU MIGHT THINK IMPORTANT FOR THE PSYCHOLOGIST TO KNOW:

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____ [PATIENT or PARENT/GUARDIAN NAME], hereby authorize the disclosure of my health information FROM Savannah Neuropsychology, 450 Mall Blvd. STE E. Savannah, GA 31406, for the purpose of evaluation and treatment TO the medical provider(s) and other methods listed below:

Referring Physician/Facility:

Personal Email:

Physician/Facility:

Physician/Facility:

I understand that the health information that may be disclosed includes, but is not limited to, the following:

- Medical records, including diagnoses, treatment plans, and medications prescribed.
- Laboratory and diagnostic test results.
- Surgical and operative reports.
- Mental health records, including therapy session notes and psychiatric evaluations.
- Substance abuse treatment records, if applicable.
- Any other pertinent health information deemed necessary for the purpose of disclosure.

I authorize Savannah Neuropsychology to obtain, use, and disclose this health information in accordance with the applicable privacy laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and any state or local laws governing the privacy and confidentiality of health information.

This authorization is valid for a period of one year from the date of signing this document unless otherwise specified. I understand that I have the right to revoke this authorization at any time by providing a written notice to Savannah Neuropsychology, except to the extent that action has already been taken based on this authorization.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION CONT.

I acknowledge that the disclosure of my health information is voluntary, and I am aware of the potential risks associated with the unauthorized use or disclosure of this information. I release Savannah Neuropsychology, its employees, agents, and representatives from any liability that may arise from the use or disclosure of my health information in accordance with this authorization.

Patient's Name:

Patient's Date of Birth:

Patient/Guardian Signature:

Relationship to Patient:

Today's Date:

Savannah Neuropsychology

INFORMED CONSENT FOR NEUROPSYCHOLOGICAL/PSYCHOLOGICAL SERVICES

You have been referred to our office for an evaluation and/or treatment. Your appointment has been scheduled with a licensed psychologist and/or a master's level psychology associate. The initial visit will consist of one or more of the clinical services listed below. We will review the evaluation/treatment plan and recommendations with the patient, at which time the patient may ask questions or voice concerns. The patient may choose to discontinue their relationship with this practice at any time during the course of evaluation and/or treatment with the understanding that fees associated with evaluation and treatment already rendered will be due and payable.

The following information is provided to the patient for review. Please sign the last page, acknowledging that you have read and understand the information provided. A copy of this information will be made available to you.

Clinical Services provided by our practice:

- A. Psychological Evaluation: consists of one or more clinical interviews with the patient and/or family members, a review of available medical and psychological records, and ***the completion of various psychological tests*** - all of which are designed to answer questions about the patient's psychological well-being, assist in making decisions concerning the patient, and assist in the treatment of the patient. These evaluations are often required as a part of surgical clearance for specific types of procedures.
- B. Neuropsychological Evaluation: a highly specialized form of evaluation to help answer questions about the health of a patient's brain, especially how well the brain is able to perform the tasks it needs to perform. This type of referral would normally be based on concern about observed changes in the patient and/or the experience of an injury or neurological disorder.
- C. Counseling/Therapeutic Services: these services are a way to help individuals with a wide variety of mental illnesses and emotional difficulties by eliminating or controlling troubling symptoms so a person can function better and increase their well-being. We primarily utilize Cognitive Behavioral Therapy (CBT), which helps people identify and change thinking and behavior patterns that are harmful or ineffective, replacing them with more accurate and functional thoughts and behaviors. It can help a person focus on current problems and how to solve them. It often involves practicing new skills in the "real world." CBT can be helpful in treating a variety of disorders, including depression, anxiety, trauma-related disorders, and eating disorders.

Confidentiality:

Patient cases are treated confidentially. This means that information about a patient is only shared with that patient and members of their treatment team, and then only in a manner necessary to enhance their care. Sensitive issues are handled very carefully - if there is a question about confidentiality, if you and your family have questions about any of the clinical services discussed, or about the financial aspects of your treatment, please call our practice manager or your psychologist.

There are some situations in which the psychologist is legally required to take action to protect others from harm, even if that requires revealing some information about a client's treatment. For example, if the psychologist believes that a child, an elderly person, or a disabled person is being abused, he must file a report with the appropriate state agency. If the psychologist believes that a patient is threatening serious bodily harm to another, he is required to take protective actions.

Informed Consent for Neuropsychological/Psychological Services Page 2

These may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If the patient threatens to harm him/herself, the psychologist may be required to seek hospitalization for the client or to contact family members or others who can help provide protection. These situations rarely arise in our practice, but should such a situation occur, the psychologist would make every effort to fully discuss the situation with the patient before taking any action.

With regard to electronic mail (e-mail) communications, we cannot guarantee complete privacy due to the nature of the Internet. We advise our patients to use this method of technology cautiously.

Professional Records:

Both Georgia state law and the standards of the field of psychology require that appropriate treatment records be kept on every patient seen by the psychologist. The patient is entitled to receive a copy of the records, unless the psychologist believes that seeing them would be emotionally damaging, in which case, the psychologist would provide them to an appropriate mental health professional of the patient's choice. Because these are professional records, they can be misinterpreted and/or can be upsetting. It is our recommendation that the records be reviewed by the patient and psychologist together so that they can discuss the content of the record.

Protected Health Information or "PHI":

Your personal medical information is called Protected Health Information or "PHI." This office and staff can use your PHI or share it with each other only in certain ways. We must follow certain rules about sharing the patient's PHI outside of our practice. You will be given the Georgia Notice Form regarding this information, how it may be used and disclosed, and how you can get access to it. Please review this Notice carefully.

Financial Responsibility

Our practice works hard to charge for services at a rate competitive for our region of the state while still meeting operating expenses. Fees reflect time spent with the patient and family, review of records, scoring and interpretation of tests, preparation of reports, and treatment planning with health care teams. Debit/Credit cards will automatically be saved to our system by default but can be removed at any time upon request.

Please note that there is a \$25 fee for missed appointments not canceled with a 24-hour notice. This fee is not covered by insurance carriers and is the patient's responsibility.

Initial Above

Services are often paid for by insurance, government programs, or other benefit programs. Each patient will need to discuss potential coverage in advance with our office staff. Patients often assume coverage beyond what is actually available to them. Any estimate we provide is offered as a courtesy and does not guarantee benefits or payment. The contract between the patient and the insurer is strictly between those parties. For any questions regarding how a claim was processed, please contact your insurance provider directly. **You will be responsible for any unpaid balances once your insurance has processed the claim.**

Your signature below authorizes the release of any necessary information to process your insurance claims, including demographic information as well as clinical notes/information. It also indicates that you have read and understand the above. A copy of the Georgia Notice Form is available at your request.

Patient/Guardian Signature

Date

Witness

Date