Neuropsychology Appointment Instructions

Thank you for making an appointment with BrainWorks Neuropsychology Consultants. Your appointment time is:_____

Please bring the following to your appointment:

1. Completed paperwork packet (attached).
2. Insurance card and driver's license
3. Bagged lunch.

The appointment can vary in length, but you should expect to be with us for about 5 hours. We will take a short lunch break.

****Please ask the referring doctor to fax to us a prescription, relevant medical records (such as a recent office visit), and demographic/ insurance information. They can fax it to 908-243-0940****

Office Address:

43 Route 202, Suite 100A
PO Box 213
Far Hills, NJ 07931

The office is in a red building. You will need to turn onto the side street, Dumont Road, to park in the lot behind the building. You can walk between the red and blue buildings to find my office in the front of the red building.

Feel free to call or email with any questions. I look forward to meeting with you.

Antoinette Welsh, Ph.D.
BrainWorks Neuropsychology Consultants, LLC
ajwelsh@brainworksnj.com
phone: 908-300-3993
fax: 908-234-0940

BrainWorks Neuropsychology Consultants, LLC

New Patient Information Form

Today's Date: _____ SS#:_____

Name: _____DOB:_____Phone#:_____

Emergency Contact

Name:_____Phone #:_____Relationship_____

Referring physician:_____

In addition to the referring physician, you may discuss any information about my treatment with the following individuals:

Name:_____ Phone#_____

Name:_____ Phone#_____

Name:_____ Phone#_____

Name:_____ Phone#_____

Primary Insurance Company:_____

Subscriber's: Name_____DOB:_____

Relationship to subscriber:_____

Policy #_____ Group#_____

Subscriber's address: _____

Secondary Insurance Company:_____

Subscriber's: Name_____DOB:_____

Relationship to subscriber:_____

Policy #_____ Group#_____

Subscriber's address: _____

Tertiary Insurance Company:_____

Subscriber's: Name_____DOB:_____

Relationship to subscriber:_____

Policy #_____ Group#_____

Subscriber's address: _____

BrainWorks Neuropsychology Consultants, LLC

Informed Consent

I _____ voluntarily give my consent to BrainWorks Neuropsychology Consultants, LLC to provide psychological services including neuropsychological assessment, psychological assessment, review of assessment findings in a scheduled feedback session, psychotherapy, and consultation. I understand that I may not agree with the results of the evaluation, but I will be given the opportunity to discuss any concerns during the feedback session. I will also be able to ask any questions about the assessment process, results and interpretation during the feedback session. Psychological services are confidential with the exception of the following situations. If there is reasonable suspicion that I am at risk of harming myself or others, BrainWorks Neuropsychology Consultants, LLC is under obligation to report that information to the appropriate authorities. If there is reasonable suspicion that child or elder abuse is occurring, BrainWorks Neuropsychology Consultants, LLC is under legal obligation to report that information to the appropriate authorities. If there is a court order, BrainWorks Neuropsychology Consultants, LLC may also be mandated to release confidential information.

BrainWorks Neuropsychology Consultants, LLC does not provide emergency psychological services. In the event of an emergency, please call 911 or go to your local emergency room.

I understand that I am responsible for all copays and deductibles not covered by my insurance.

I have read this form and I understand this information. I am consenting voluntarily to psychological services and I understand that my consent can be revoked at any time.

_____
Patient's Name (printed)

_____ Date _____
Patient's Signature

BrainWorks Neuropsychology Consultants, LLC

Use and Disclosure of Protected Health Information

I give my consent to BrainWorks Neuropsychology Consultants, LLC to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations. I have been given a copy of the notice of privacy practices from the US Department of Health and Human Services, which describes this in more detail. I have been given the opportunity to review these privacy practices prior to signing this consent. Any use or disclosure of my protected health information not listed in this notice of privacy practices requires a signed authorization before any protected health information is released. BrainWorks Neuropsychology Consultants, LLC is required to inform me if there is a breach in this process where my information has been released without my written consent.

I give my consent to BrainWorks Neuropsychology Consultants, LLC to contact me by email and by phone at the numbers I provided on the New Patient Information Form for the purpose of scheduling appointments, insurance issues, or for any issues related to my treatment. I have specified on the New Patient Information Form whether it is okay for BrainWorks Neuropsychology Consultants, LLC to leave a message. I give my consent to BrainWorks Neuropsychology Consultants, LLC to send a final report of the neuropsychological evaluation to the referring physician for the purposes of healthcare treatment and coordination of care.

I understand that I can revoke this consent in writing at a later time, with the exception of information that has already been disclosed.

Patient's Name (printed): _____

Patient's Signature:_____Date: _____

BrainWorks Neuropsychology Consultants, LLC

Please take some time to complete this form in its entirety. Your responses to the following questions are very important and will allow us to gain a better understanding of you and any current problems. We are aware that it may be difficult to remember certain dates and events. In such instances, please provide your best estimate.

~Please answer every question~

Today's Date: _____ SS#:_____

Name: _____
(First) *(Middle Initial)* *(Last)*

Date of Birth:_____ Age:_____ Sex: ❑ Male ❑ Female

Address:_____

Home phone: _____Okay to leave message? ❑ yes ❑ no

Cell phone: _____Okay to leave message? ❑ yes ❑ no

Email address:_____

Writing hand*:* ❑ Right ❑ Left ❑ Ambidextrous Ethnicity:_____

Highest Level of Education: _____

Primary language:_____

Who referred you for this evaluation?_____ Telephone#:_____

Address:_____

Why were you referred (e.g. stroke, head injury, memory problems, etc.)?_____

_____

Date problem began/occurred: _____

Have you ever had neuropsychological or psychological testing before: ❑ yes ❑ no

If yes, by whom?_____ when?_____

Please list all of the medications that you are currently taking, including dosages (or you may attach a list):

MEDICATION	DOSE	HOW OFTEN	REASON

If you have a case manager, please provide:

Name:_____ Telephone#:_____

Address:_____

Please describe your current symptoms:_____

_____

_____

Developmental History

History of developmental delays as a child (e.g. early problems walking or talking)? ❑ yes ❑ no

If so, please describe:_____

Did you have any serious injuries as an infant or child? ❑ yes ❑ no

If so, please describe:_____

Medical History

Please list any medical conditions:

Condition:_____Year of diagnosis:_____❑ Resolved ❑ Ongoing

Condition:_____Year of diagnosis:_____❑ Resolved ❑ Ongoing

Condition:_____Year of diagnosis:_____❑ Resolved ❑ Ongoing

Condition:_____Year of diagnosis:_____❑ Resolved ❑ Ongoing

Condition:_____Year of diagnosis:_____❑ Resolved ❑ Ongoing

Have you ever had a head injury (e.g. concussion, TBI, skull fracture, etc.)? ❑ yes ❑ no

If yes, please indicate the following:

Type of head injury:_____Year_____

Were you medical evaluated following the head injury? ❑ yes ❑ no

Type of head injury:_____Year_____

Were you medical evaluated following the head injury? ❑ yes ❑ no

Type of head injury:_____Year_____

Were you medical evaluated following the head injury? ❑ yes ❑ no

Have you ever had any of the following procedures?

(*Please circle)*

MRI/MRA Year:_____Results:_____

CT Scan Year:_____Results:_____

EEG Year:_____Results:_____

PET Scan Year:_____Results:_____

MEG Scan Year:_____Results:_____

Describe any hearing or vision problems:_____

Describe any changes in appetite:_____

Describe any changes in sleep:_____

Describe your overall energy level:_____

Describe any pain that you experience:_____

Family HIstory

Father: ❑ alive ❑ deceased

Present age_____ If deceased, age at death_____ Cause of death_____

Mother: ❑ alive ❑ deceased

Present age_____ If deceased, age at death_____ Cause of death_____

Is there any **family** history of the following conditions *(check all that apply)*?

- ❑ Dementia…….In who?_____
- ❑ Alzheimer's……..In who?_____
- ❑ Parkinson's disease……In who?_____
- ❑ Huntington's disease……..……In who?_____
- ❑ Pick's disease…….In who?_____
- ❑ Multiple sclerosis……..In who?_____
- ❑ Epilepsy/seizures…….In who?_____
- ❑ Stroke…….In who?_____
- ❑ Brain tumor…….In who?_____
- ❑ Heart attack/heart disease……..In who?_____
- ❑ Depression……..In who?_____
- ❑ Anxiety…….In who?_____
- ❑ ADD/ADHD…….In who?_____
- ❑ Schizophrenia…….In who?_____
- ❑ Bipolar Disorder……..In who?_____

Educational and Employment History

List any problems in school (e.g. learning disabilities, ADHD, behavioral problems, etc.):_____

_____

Were you ever in special education? ❑ yes ❑ no

Were you ever held back a grade? ❑ yes ❑ no If so, which grade?_____

College/graduate school major (if applicable):_____

Are you currently employed? ❑ yes ❑ no ❑ retired ❑ disabled

If yes, where?_____

Job title:_____Years in current job:_____

If no, last place of employment:_____

Job title:_____ Date last worked:_____

Social History

Are you: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

List any other people in your home:_____

Indicate each child's age and sex:

Age_____❑ Male ❑ Female Age_____❑ Male ❑ Female

Age_____❑ Male ❑ Female Age_____❑ Male ❑ Female

Age_____❑ Male ❑ Female Age_____❑ Male ❑ Female

Age_____❑ Male ❑ Female Age_____❑ Male ❑ Female

Age_____❑ Male ❑ Female Age_____❑ Male ❑ Female

Describe any current or recent stress related to family, work, illness, traumatic events, or other causes.

_____

_____

_____

What do you do for fun?

_____

_____

Mental Health History

Have you ever been hospitalized for psychological/psychiatric reasons? ❑ yes ❑ no

If yes, please indicate the following:

Where:_____When:_____ Length of Stay:_____
Where:_____When:_____ Length of Stay:_____
Where:_____When:_____ Length of Stay:_____

Have you ever been diagnosed with any of the following conditions?

❑	Depression	❑	Learning difficulties	❑	Bipolar Disorder
❑	Anxiety	❑	Obsessive Compulsive Disorder	❑	Anorexia or Bulimia
❑	ADD/ADHD	❑	Post-Traumatic Stress Disorder		
❑	Schizophrenia	❑	Borderline Personality Disorder		

Are you currently working with a counselor or a therapist? ❑ yes ❑ no

If so, please provide:

Name:_____ Telephone:_____

Address:_____

Substance Use and Legal History

Do you now, or have you previously consumed alcohol? ❑ yes ❑ no

About how many drinks do you have on average per week?_____

Do you have a history of treatment for excessive alcohol use? ❑ yes ❑ no

If yes, when?_____ where?_____

Do you use tobacco? ❑ yes ❑ no

If you smoke cigarettes, how many do you smoke per day?_____

Do you use any other drugs? ❑ yes ❑ no

If yes, please list:_____

Have you ever been arrested? ❑ yes ❑ no

If yes, please explain:_____

Are you currently involved in any legal proceedings or law suites? ❑ yes ❑ no

If yes, please explain:_____

_____

_____

Do you have an active driver's license? ❑ yes ❑ no

Has your driver's license ever been suspended or revoked? ❑ yes ❑ no

If yes, please explain why: _____

END

Thank you for taking the time to respond to these questions. The information that you provided is important to help us better understand any current problems that you may be experiencing. Please return this completed form.

Antoinette Welsh, Ph.D.
BrainWorks Neuropsychology Consultants, LLC

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully. Effective date: October 15, 2018**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.