512 Poyntz, Suite 110
Manhattan KS 66502-2853
tel: 785-236-1180/fax: 785-789-4048
flinthillsneuropsych.com

New Patient Information (Adult)

Name: _____ Date of Birth: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ (Circle: Home Work Cell Other contact: _____)

Phone: _____ (Circle: Home Work Cell Other contact: _____)

Email address: _____

Employer (or if a student, list school, year/grade, and degree program):

_____

What is your preferred method for appointment reminders? (circle) Email Text Phone call

Occupational Status:

_____Full-time student
_____Part-time student
_____Homemaker
_____Retired
_____Disability
_____Unemployed
_____Part-time employed
_____Full-time employed

Occupation/Job title:

_____

Handedness (circle):

Right/Left

Education:

_____GED
_____High School
_____Associates
_____Bachelors
_____Masters
_____PhD/professional

Marital Status:

_____Single
_____Live-in/partnered
_____Married
_____Separated
_____Divorced
_____Widowed

Ethnicity:

_____Other
_____African American
_____Caucasian
_____Asian
_____Native American
_____Hispanic
_____Pacific Islander
_____Arabic

Emergency Contact: Please list an adult we may call in case of an emergency.

Name: _____ Address:_____

Relationship to you: _____ Phone Number: _____

Do you have a legal guardian, conservator, or power of attorney? Yes/No

Name: _____ Address:_____

Relationship to you: _____ Phone Number: _____

Please list any individuals with whom you allow us to share your health information:

Name/Phone: _____ Relationship:_____
Name/Phone: _____ Relationship:_____

Health History

What brings you in for assessment?

_____

_____

How long have you had this problem? _____

Are these symptoms the result of an injury? Yes____ No____ If so, date of injury: ____/____/_____

Was it a motor vehicle accident? Yes____ No____ Were you injured at work? Yes____ No____

Are you represented by an attorney? Yes____ No____ If so, name of attorney:_____

Please list your current primary care physician: PHYSICIAN:_____

Please list your current mental health provider: PROVIDER:_____

Please list any other health care providers:

PHYSICIAN:_____ SPECIALTY:_____

PHYSICIAN:_____ SPECIALTY:_____

PHYSICIAN:_____ SPECIALTY:_____

List any chronic medical conditions:

List any surgeries (with year):

Describe any neurological history such as TBI, seizures, stroke, or neurological disorder:

Describe any history of problems with mental health:

Describe any history of addictions such as alcoholism or drug abuse:

Describe any problems with vision and/or hearing:

Please list the names and dosage of any prescription or non-prescription medication you are currently taking including vitamins, herbals, or supplements (or, you may bring a separate list):

MEDICATION DOSAGE

Is there a family history of:

ADHD, learning disability, autism? Yes/No Relationship and diagnosis:_____

Depression, anxiety, mental illness? Yes/No Relationship and diagnosis:_____

Alzheimer's, Parkinson's, dementia? Yes/No Relationship and diagnosis:_____

Neurological conditions like MS or epilepsy? Yes/No Relationship and diagnosis:_____

Heart disease or stroke? Yes/No Relationship and diagnosis:_____

Health Insurance and Payment Information:

Policy holder's name as it appears on the card (if not in your name):_____

Policy holder's birthdate: ____/____/____ Your relationship to policy holder: _____

Will you be paying for any out-of-pocket costs yourself or will they be paid by another party?

Self-pay: _____ Other (name and billing information): _____

_____

Informed Consent & HIPAA Acknowledgment

I hereby authorize Flint Hills Neuropsychology psychologists and/or such assistants as may be requested by the supervising psychologist to perform medical services as follows:

Psychological evaluation beginning with an intake appointment, followed by testing, and a feedback session during which results, diagnoses, and recommendations are discussed. A summary report will be written and sent out to any health care providers or other parties designated by me (such as schools, etc.). The associated risks are minimal but some interview questions may be personal, and some tests may be difficult and/or frustrating. I acknowledge that it is important to respond honestly and make full effort on tests in order for the results to be valid and accurate. I further acknowledge that I do not need to answer all interview or test questions but that by not doing so, the usefulness of the evaluation may be limited.

I authorize the release of any medical information necessary to process my claim and payment of benefits.

I hereby acknowledge and agree that if my insurance does not cover the medical services, I will be personally responsible for paying the financial charges for those services.

I acknowledge that no warranty or guarantee has been made as to the results of this assessment or treatment recommendations. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my provider.

I have reviewed the Informed Consent & HIPAA document offered to me and/or that is available online (http://www.flinthillsneuropsych.com) and I understand my rights and responsibilities.

I understand that there is a $250 fee billed directly to me for psychological testing sessions that are missed or canceled with less than 72 hours notice, and a $50 fee billed directly to me for any other sessions that are missed or canceled with less than 24 hours notice (such as intake, feedback, or speech-language sessions). These fees do not apply for patients covered by Medicaid per state regulations.

I have read and agree to the above:
Signed_____ Date_____

Patient's Name (Please Print): _____