FLINT HILLS neuropsychology

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

New Patient Information (Child)

Name: _____ Date of Birth: _____

Parent/Guardian 1 Name and Phone: _____ (Home Work Cell)

Parent/Guardian 1 Email address: _____

Parent/Guardian 2 Name and Phone: _____ (Home Work Cell)

Parent/Guardian 2 Email address: _____

Patient Phone (if applicable): _____

Primary Address/Household:

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

Who lives in this household? _____

Secondary Address/Household (if applicable):

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

Who lives in this household? _____

Child's School and Grade:
_____
_____

Does your child have an IEP or a 504 plan? ____ Yes ____ No

*If your child has an IEP or a 504 plan it is ESSENTIAL that we receive a copy.

Has your child repeated a grade in school? ____ Yes ____ No
If so, which grade? _____

Please check if your child has ever received:
_____ Special Education/Resource Room Services
_____ Occupational Therapy
_____ Physical Therapy
_____ Speech/Language Therapy
_____ Social Work/Counseling at School
_____ Paraeducator Support
_____ Behavior Plan
_____ After-school Tutoring/Help
_____ Summer School

Handedness (circle):
Right/Left

Ethnicity:
_____Other
_____African American
_____Caucasian
_____Asian
_____Native American
_____Hispanic
_____Pacific Islander
_____Arabic

Health History

What brings your child in for assessment?

_____

_____

How long has your child 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____

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

Please list the current primary care physician: PHYSICIAN:_____

Please list the current mental health provider: PROVIDER:_____

Please list any other health care providers:

PHYSICIAN:_____ SPECIALTY:_____

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PHYSICIAN:_____ SPECIALTY:_____

Was your child born full term? Yes____ No____ If not, how many weeks gestation? _____

Any complications of pregnancy or delivery? _____

_____

Birth weight:_____

Were there any delays in early developmental milestones (walking, talking)?

_____

_____

Indicate any chronic medical conditions:

_____

_____

_____

List any surgeries (with year):

_____

_____

Describe any neurological history such as TBI/concussion, seizure, migraines, or neurological disorder:

_____

_____

Describe any problems with behavior or mental health:

_____

_____

List any problems with vision and/or hearing:

_____

_____

Please list the names and dosage of any prescription or non-prescription medication your child is 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:_____

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

Health Insurance and Payment Information:

Policy holder's name as it appears on the card:_____

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

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 for my child 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 my child and 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 the 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_____

Name and relationship to child (please print): _____

Signer birthdate: ____/____/____