4241 B Street, Suite 202, Anchorage, AK 99503
Phone: 907-277-0100 Fax: 907-222-0566
alaskaneuro.com

Thank you for choosing Alaska Neuro Associates, LLC (ANA), where you will receive a comprehensive neuropsychological evaluation and relevant recommendations regarding your referral concerns. In order to provide the best evaluation possible, we have assembled a "Registration" packet for your review and completion. You will need to complete the packet and return it ***prior to*** scheduling your appointment. If for any reason you are unable to complete the packet in a timely manner, please call our office. The information you provide will be used by the Neuropsychologist during the interview to better focus their time and attention on your specific concerns. We ask that you thoroughly and accurately complete the questionnaire and return it at least one week prior to your appointment. Short term cancelling of your appointment less than 48 business hours prior to the appointment may result in a $500.00 fee that your insurance will not pay.

If you have any questions, please feel free to contact our office at (907) 277-0100.

Included within this packet:

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Neuropsychological/Psychological Evaluation

You have been referred for a neuropsychological evaluation with Alaska Neuro Associates, LLC (ANA). Your appointment is scheduled for:

Date: ________________ Time: ___________ Doctor: (Russell Cherry, PsyD/Heather Macomber, PhD)

What is a neuropsychological evaluation?
A neuropsychological evaluation is a complex process that integrates information from a wide variety of sources in order to develop a clear picture of who the person is, assess how they are functioning, and determine what may be interfering with their ability to function more effectively. A neuropsychological evaluation relies on multiple sources of data and examines cognitive abilities, brain-behavior relationships, adaptive abilities, and psychological/personality functioning. The comprehensive nature of such an evaluation enables more accurate diagnoses, determines areas of strength and weakness, and provides relevant recommendations, such as the need for academic, psychological/psychiatric, medical, and vocational interventions.

Who is involved in my care?
Neuropsychologist – A doctoral-level, licensed clinical psychologist with extensive specialized postdoctoral training in clinical neuropsychology.
Psychometrist – A professional who administers and scores neuropsychological tests under the supervision of a Neuropsychologist. *Please note: the psychometrist cannot provide you with any information about your test results or diagnosis.*

How long does it take?
The duration of the testing process varies based on the nature of the referral question and the complexity of your situation. The testing typically takes between four to six hours.
Note: If you are not well-rested for your evaluation appointment, this will negatively affect your test performance and make it more difficult for the Neuropsychologist to determine an accurate diagnosis. Therefore, if traveling from outside the Anchorage bowl area for a morning appointment, please find accommodations for the evening prior to your evaluation.

How do I prepare for the evaluation?

- Arrive **30 minutes early** for your appointment.
- **If the patient is nonverbal, MDI, TBI, gravely impaired or unable to provide accurate information regarding their situation, then they *MUST* be accompanied by an adult who is familiar with their history and current issues.**
- Make sure you get plenty of sleep the night before the appointment.
- Bring any hearing aids, contacts or glasses, if you have them.
- Eat before the appointment and bring a snack.
- Bring a list of your current medications (and doses)
- Bring **any medical or school records** you have (recent and past) related to your problem.

When can I get the results?
After your initial appointment, you will schedule a feedback appointment for approximately three to four weeks later, at which time you will receive your report. The Neuropsychologist will discuss your test results and answer your questions, and this collaborative process may result in additional recommendations. Please allow for one hour for this appointment. **If you have any questions, please contact our office at (907) 277-0100.**

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PATIENT REGISTRATION FORM

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is the adult responsible for the bill?

Last Name: ____________________________ First Name: ___________________________ M.I.:___________

Relationship to Patient: _____________________________Photo ID and Proof of Guardianship Required

Any patient under the age of 18 and those requiring a guardian beyond the age of 18 must have their guardian remain in our office throughout the evaluation process.

Marital Status: M / S / D SSN: __________________________ DOB: ______________________ Sex: M / F

Address: ____ City __________________ State ____ Zip ________

Home Phone: __________________ Cell Phone: ____________________ Work Phone: __________________

Email address________________ I authorize the use of this email address for scheduling and billing purposes

Employer's Name, Address & Phone:

____

____

PATIENT INFORMATION

Last Name: ____________________________ First Name: ___________________________ M.I.:___________

SSN: _________________________ Marital Status: M / S / D Sex: M / F DOB: ______________________

Address: ____City __________________ State ____ Zip ________

Home Phone: __________________ Cell Phone: ____________________ Work Phone: __________________

Employer's Name, Address & Phone:

____

Emergency Contact:

Name: _________________________ Address: ____________________________ Phone: _________________

Relationship to patient:____

PRIMARY INSURANCE - ALL INFORMATION MUST BE PROVIDED

Insurance Name & Address: ____

Policy #: __________________________ Group #: _____________________ Effective Date: _______________

Policy Holder: ________________________________ Relationship to Patient: ____________________________

SSN: ___________________________________ Date of Birth: __________________________ M_____F_____

Employer Name, Address & Phone:

____

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SECONDARY INSURANCE - IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED

Insurance Name & Address: ____

Policy #: ______________________ Group #: ___________________ Effective Date: _____________

Policy Holder: ____________________________ Relationship to Patient: _________________________

SSN: ______________________________ Date of Birth: ______________________ M_____F_____

Employer Name, Address & Phone:

____

TERTIARY INSURANCE - IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED

Insurance Name & Address: ____

Policy #: ______________________ Group #: ___________________ Effective Date: _____________

Policy Holder: ____________________________ Relationship to Patient: _________________________

SSN: ______________________________ Date of Birth: ______________________ M_____F_____

Employer Name, Address & Phone:

____

Patients are responsible for knowing whether or not and to what extent their insurance plans cover. It is the plan holder's responsibility to determine if their insurance plan requires any preauthorization or precertification for services. Insurance coverage is not a guarantee of payment. You are responsible for paying any balance that is not covered by your insurance. Please call our billing department for any questions. **Charges for a neuropsychological evaluation range from $4,600.00 - $5,200.00 for the interview and neuropsychological testing, and the feedback session additional $425.00 at a later date to review the test results, diagnoses and relevant recommendations.**

I hereby declare the information provided herein is true and correct to the best of my knowledge.

____ ________________________________

Patient/Responsible Party Signature **Date**

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CLINIC POLICIES

Thank you for choosing Alaska Neuro Associates, LLC (ANA), where you will receive a comprehensive neuropsychological evaluation and relevant recommendations regarding your referral concerns. The purpose of this form is to provide you with important information regarding confidentiality and responsibility for payment of services.

CONFIDENTIALITY: Information obtained during the current evaluation is considered confidential and can ordinarily only be released to other parties with your written permission. If you divulge information about the abuse of child, vulnerable adult, or elder, then we are required by law to report this to the appropriate authorities. Additionally, if you threaten to harm yourself, someone else, or the property of others, we may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm. Finally, if ordered by the court, we may have to testify or release your records. Please ask the front desk staff for a release of information if you want us to be able to speak with additional family members or providers other than the referral source about your care. We will forward a copy of the report to the referral source.

Patient/Responsible Party initials ________________

CHILDREN: A parent or legal guardian must accompany all children under the age of 18 years. No child is to be left in the waiting room at any time without adult supervision. In order to be able to participate fully in the evaluation process, parents are asked to only bring the child who is to be seen to the appointment. If you are unable to make prior arrangements for any additional children, please call our office to reschedule the appointment no later than 48 business hours prior to the appt.

CANCELLATIONS/NO SHOW: We complete a courtesy reminder call and/or text/email 1 week in advance of each appointment. You are responsible for confirming your appointment by responding to prompts during the call and/or via text/email. This ***MUST*** occur within 48 business hours of your scheduled appointment time, or your appointment will be cancelled. If you are cancelling your appointment, you ***MUST*** do so at least 48 business hours in advance, directly with a staff member during business hours, otherwise you will be charged a "No Show" fee of $500.00. For feedback appointments, the appointment ***MUST*** be cancelled with at least 48 business hours' notice, or you will be charged a "No Show" fee of $50.00. **Insurance will not be billed for "No Show" fees. These fees will not be removed regardless of the reason the appointment was missed.**

Patient/Responsible Party initials ________________

FINANCIAL: As a courtesy, we will bill your insurance if you provide **accurate proof of coverage** at the time of service. You are expected to pay any/all deductibles and co-pays designated by your insurance plan. If you fail to pay your final bill or to make financial arrangements to settle your account within thirty (30) days of receiving your statement, your account will be sent to collections. We accept cash, check, Visa, and MasterCard. Billing statements and receipts will be sent electronically if an email address has been provided. Your provision of the email address shall be considered your consent.

Patient/Responsible Party initials ________________

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: Charges for a neuropsychological evaluation range from $4,600.00 - $5,200.00, and the feedback session additional $425.00. In order to bill my insurance I understand that they will have access to reports from services provided by ANA. I authorize the exchange of information necessary for payment of services. I authorize payment directly to ANA for services rendered to me regarding my evaluation. I also understand that I am responsible for any amount not covered or that is deemed over usual and customary fees by my insurance carrier or agency. **Self-paying patients:** I understand that I am responsible for my bill and that an initial payment of $5,000 is expected prior to the start of the evaluation process unless prior arrangements have been made.

Patient/Responsible Party initials ________________

Alaska Neuro Associates, LLC clinic policies and privacy practices have been reviewed, understood and agreed to by me.
Patient Name: [print] ___________________________________ Date: _________

Patient/Responsible Party Signature ____

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CONSENT FOR NEUROPSYCHOLOGICAL/PSYCHOLOGICAL EVALUATION

You have been referred for a neuropsychological evaluation (i.e. formal evaluation of your cognitive abilities) with Russell Cherry, PsyD or Heather Macomber, PhD. Please read this document carefully, as your signature will represent an agreement between you and Alaska Neuro Associates, LLC (ANA).

The goal of neuropsychological evaluation is to determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive abilities. A neuropsychological evaluation may point to changes in brain function and suggest possible methods and treatments for rehabilitation.

The first part of the evaluation is an interview, which will entail asking questions about your background and current medical problems/symptoms. Although we try to be thorough during interviews, we may not ask about some areas or information that you believe are relevant or important to your current problems. If so, please tell us so that we can discuss it. Conversely, we may ask you questions that seem irrelevant to you/your condition, but based on our clinical judgment, they are necessary to better understand your condition. You are encouraged to bring or make available any documents that speak to your cognitive abilities before your problems began, such as school transcripts, work records, or employee evaluations. As part of conducting a comprehensive evaluation, your Neuropsychologist will likely request a number of documents relevant to your condition from a variety of sources including, but not limited to, your psychiatrist, neurologist, therapist/counselor, radiologist, primary care provider, hospitals, employer, and any other entities that would provide information pertinent to your condition.

Please be aware that you are encouraged to have a family member/significant other present during the interview to help provide information regarding your problems, but that they *may not* be present during testing. It is also the policy of this office and American Academy of Clinical Neuropsychologists/National Academy of Neuropsychology guidelines that third party observers (e.g., attorney, advocates, etc.) or recording devices are not allowed during the interview or testing.

In the second part of the evaluation, different techniques and standardized tests will be introduced including, but not limited to, asking questions about your knowledge of certain topics, reading, drawing figures and shapes, viewing printed material, solving puzzles, using a computer keyboard, and manipulating objects. You are to give your best effort during the testing and answer truthfully. That does not mean that you must answer every problem correctly, as no one ever does. However, this part of the examination will assess the accuracy of your responses, as well as the degree of effort that you exert on the tests. Additionally, you will be asked to complete various questionnaires assessing your psychological/personality functioning. It is extremely important that you be as truthful as possible when answering these questionnaires.

After the test results are obtained, the Neuropsychologist will interpret this information in a comprehensive report. The report will contain test data, provide detailed analysis of neuropsychological and psychological results, summarize the entirety of information and provide DSM-V-TR/ICD-10 diagnoses, and provide relevant recommendations.

I understand that I have the right for my personal information to be kept private and that information may be discussed between ANA staff members only to the extent that it ensures quality care. I understand that my rights to privacy are limited by state and federal law; and only in an emergency or if it is required by law will records be released without my written consent. These circumstances include, but are not limited to:

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1) If I divulge information about the abuse of child, vulnerable adult, or elder, then ANA is required by law to report this to the appropriate authorities, which may include Adult Protective Services, Office of Children Services, and/or law enforcement.
2) If I threaten to harm myself, someone else, or the property of others, ANA may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm.
3) If ordered by the court, the Neuropsychologist may have to testify or release my records.

I understand that if I am giving consent for a minor child or someone over the age of 18 for whom I have legal guardianship, it is incumbent upon me to inform any other parent or legal guardian prior to giving consent and my signature below constitutes my attestation to having full authority and agreement on the part of all parties involved for consenting to the neuropsychological evaluation process. I hereby release Alaska Neuro Associates, LLC and shall hold them harmless from any obligation real or implied to inform any other parent or legal guardian or obtain additional consent from any other party as my signature shall serve as permission granted by all parties involved and I will assume full responsibility for any other parent or legal guardian's consent.

I understand that I have the right to terminate the evaluation whenever I wish. I also recognize that in taking such action, the Neuropsychologist will be unable to complete the evaluation, generate a report, and provide valuable information to me and my referral source regarding my issues/concerns.

I understand the Neuropsychologist also has the right to terminate the evaluation at any point should they become aware of any pending litigation, i.e., open custody cases, contested guardianship cases, worker's comp. automobile accident injury claim, parenting capacity/appealing terminated parental rights, etc., for which their report may be used. In which case, the evaluation will not be completed, a report will not be issued, insurance will not be billed and the patient will be solely responsible for payment of the time spent prior to the discovery of the undisclosed legal issues.

I understand if I am non-cooperative with the evaluation, as defined by refusal to answer interview questions, or evidencing hostile or belligerent behavior towards the examiner or any ANA staff, the appointment will be cancelled, and you will be billed accordingly, without opportunity for further rescheduling. If it is discovered that I have attend the appointment under the influence of drugs or alcohol I will not have the ability to have a re-evaluation or retake the performed neuropsychological test battery. The neuropsychologist has the right to consider not accepting any future referrals or scheduling future appointments for myself.

The terms of this evaluation have been reviewed, understood and agreed to by me.

______________________________	________________
Patient Signature	Date
______________________________	________________
Witness Signature (only needed for "X" signature)	Date
______________________________	________________
Parent or Legal Guardian Signature	Date

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PICTURE CONSENT

I authorize Alaska Neuro Associates, LLC (ANA) to take a picture for the purpose of the neuropsychological evaluation process. I understand that this picture will remain in my record for patient identification purposes.

____
Signature of Acknowledgement

____
Date

HIPAA ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I was offered a copy of the ANA notice of Privacy Practices. I also acknowledge that pursuant to **Ethical Standard 9.04** "**Release of Test Data,"** the "Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law." It is ANA standard policy that raw test data will not be released to anyone other than a licensed Neuropsychologist qualified to interpret the data.

____
Signature of Acknowledgement

____
Date

AMENDMENT POLICY ACKNOWLEDGEMENT

It is ANA policy that patient records will not be amended if the requested change does not directly affect the diagnosis and/or treatment recommendations.

By my signature below, I acknowledge this policy and that any request to amend my final neuropsychological evaluation will be denied if the requested information to be changed does not directly affect the diagnosis or treatment recommendations.

____
Signature of Acknowledgement

____
Date

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NEUROPSYCHOLOGY PATIENT HISTORY QUESTIONNAIRE

PLEASE NOTE: THE FOLLOWING INFORMATION IS NECESSARY TO CONDUCT A THOROUGH EVALUATION. THIS FORM MUST BE COMPLETED& RETURNED PRIOR TO THE APPOINTMENT.

DEMOGRAPHIC INFORMATION

Patient Name:____________________________ Date of Birth: ___________ Age:________ Gender: M F

Mailing Address: ____

Street City State Zip

Primary Language: English Spanish Alaskan Native ________ Handedness: R L Race/Ethnicity:_________

Who referred you to this evaluation? ____

Who is your Primary Care Physician? ____

When did the problem first start? (List month, year) ___________________

How has the problem changed over time? Better Same Worse

What question would you most like to have answered by this evaluation?

____

PATIENT PROBLEM AREAS

Memory Problems: Circle any problems with remembering the following:

Childhood	Events 10-20 years ago	Names of family/friends	Recent conversations
Events yesterday	Appointments	Misplacing items	Information just read
Medications	Remember shopping items	Phone numbers/addresses	Future chores

Attention Problems: Circle any problems with attention for the following:

Follow book/movies Focus for lengthy periods Mind wanders Doing two things at the same time ADHD

N/A

Language Problems: Circle any problems with language for the following:

Understanding others	Not knowing the names of things	Feels that others speak to fast	Recent conversations
Spelling/Dyslexia	Organizing their written work	Reading comprehension	Getting to the point when talking
Being overly literal	Asking others to repeat themselves	Understanding big words/long sentences	N/A

Spatial Orientation: Circle any problems with orientation for the following:

Lost in familiar places	Getting lost easily	Recent driving accidents	Right-left confusion
No sense of direction	Can’t operate common household items	Poor depth perception	Poor coordination/ being clumsy

Processing Speed: Circle any problems with processing for the following:

Doing math in head quickly	Taking longer to figure things out	Feeling mentally “slowed”
Slow to respond	Slow reaction time	Slower than other to complete things

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Executive Functioning: Circle any problems with executive (higher-order ability) for the following:

Organization	Planning ahead	Impulsive behavior	Money management
Completing assignments/projects	Doesn't learn from mistakes	Adapting to change	Multiple-step tasks
Doesn't complete tasks/projects	Time awareness	Organization of things	Lives only "in the moment"
Solving new problems	Understanding new situations	N/A	

Sensory/Motor Skills -

Shuffling gait/Unsteady on feet	Can't pick up small items	Shaky handwriting	Moves really slow
Tripping/Falling	Can't open jars/Weak grip	No sense of smell/taste	Hand tremors
Color blind	Far sided/Near sided	N/A	

Mood/Behavior: Circle any problems with the following:

Confusion	Depression	Irritable	Angry	Euphoric	Mood too "high"
Feels empty	Guilty	Frightened	Suspicious	Argumentative	Psychosis
Personality	Mania/hypomania	PTSD	Anxiety	Sleeping	Appetite
Sexual	Delusional	Paranoid	Preoccupied	Suicidal	Criminal
Apathetic	Rapid Mood Changes	Repetitive body movements	Nightmares	Perfectionist	Loner

List all prior psychiatric diagnosis:

____

Please describe any recent personality changes:

____

Adaptive Functioning: Do you/patient require help with any of the following? **Yes or No?** Circle all that apply

Toileting	Feeding	Dressing	Grooming	Walking
Bathing	Using the phone	Shopping	Cooking	Housekeeping
Laundry	Driving/use bus	Medications	Finances	N/A

Does someone help you/patient with the above activities of daily living? Yes / No List:

____

Is there a case manager/rep payee/social worker? Yes / No Who:

____

Does the problem cause you/patient difficulty with school or work?

____

DEVELOPMENTAL HISTORY

During pregnancy, did your/patients mother have any of the following problems? Circle all that apply

Use alcohol and/or drugs	Infection	Traumatic accident

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At the time of birth, did you/patient have any of the following problems? Circle all that apply

Premature	Underweight	Birth defect	"Breech" birth	Vision
Cord around neck	Hearing	Infection	"Blue" baby	Lengthy hospitalization

Compared to other children, did you/patient have difficulty with doing the following?

Walking	Talking words	Talking sentences	Bladder trained	Bowel trained

During the first six years of life, did you/patient have problems with any of the following?

Sucking/feeding	Sleeping	Colic	Ear infections
High fevers	Clumsy/uncoordinated	Nightmares	Sleepwalking
Aggression	Sensitive to touch	Hyperactive	Separation from parent

List any childhood illnesses that required hospitalization:

____

MEDICAL HISTORY

List all current medical problems:

____

Have you/patient had any problems with the following medical issues: Circle all that apply

Heart disease/stroke	Hypertension	Cancer	Asthma/bronchitis	Diabetes	Renal/kidney
Infection	Tuberculosis	HIV/AIDS	Seizure disorder	Epilepsy/seizure	Headache
Parkinson's	Thyroid	Anemia	Crohn's	Ulcers	GERD
Hepatitis	Acid reflux	Infertility	UTI	Visual	Auditory
Arthritis	Herpes	High fever	TIA	Apnea	Toxic exposure
Meningitis	Encephalitis				

Have you/patient ever been hit in the head and knocked unconscious: Yes / No (if so, list when):

____

Do you/patient have any of the following neurological symptoms? Circle all that apply

Fainting	Dizziness	Rapid heartbeat	Fatigue	Insomnia
Tremor	Chronic pain	Balance	Coordination	

Do you/patient have pain in any of the following areas? Circle all that apply

Scalp	Head	Eyes	Ears	Jaw	Neck
Shoulders	Respiratory	Elbows	Hands	Gastrointestinal	Hips
Genitals	Buttocks	Thighs	Knees	Calves	Feet

Please list any prior hospitalizations or major surgeries:

____

Please list your most recent outpatient visit (who seen, what reason):

____

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MEDICATIONS:

Please list all current medications:

Drug Name:	Dosage:	Prescribing Doctor:
_______________________	_____________________	_______________________________
_______________________	_____________________	_______________________________
_______________________	_____________________	_______________________________
_______________________	_____________________	_______________________________
_______________________	_____________________	_______________________________
_______________________	_____________________	_______________________________

Please list any over the counter medications/herbal remedies:

Name & Dosage:

____

FAMILY MEDICAL HISTORY:

List how many biological brother(s) ________________/sister(s) ____________________ of yourself/patient

What is your/patient's birth order (e.g., 3rd) ____

If you/patient were adopted or raised by someone else, at what age: __________________________________

Father's Employment _________________________ Mother's Employment _________________________

If parents are deceased, what from: Father ________________________ Mother _______________________

Have the patient's parents or siblings had problems with any of the following disorders?

Dementia	ADHD	Learning disorder	Mental retardation	Schizophrenia	Depression
Personality disorder	Bipolar	PTSD	Anxiety	Epilepsy	Alcoholism
Drug abuse	Diabetes	Antisocial	"Nervous breakdown"		

PSYCHIATRIC:

(For you/patient) When I look back at my childhood, I would describe myself as a _________________ child.

(For you/patient) As a child, my mood was generally ___________________ because of _________________

Did you/patient have problems with childhood abuse (Circle all that apply); physical, sexual, emotional, neglect,

Have you/patient ever been psychiatrically hospitalized? If Yes, please list the first, total number and most recent:

____

At what age was your/patient's very first contact with a mental health provider (psychologist; psychiatrist; therapist):

____

List any prior psychiatric diagnosis: ____

____

Do you/patient currently receive mental health services? (e.g., medications; individual therapy; group therapy)

where:____

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Any problems with: Circle all that apply

Sleep (getting to sleep, waking up, disrupted) Appetite (increased/decreased)

Libido (increased/decreased) Suicidal intention (long ago, recent)

Have you/patient ever tried to hurt themselves (first time, most recent, total number of times):

____

Do you/patient have any problems with the following: Circle all that apply

Thinking of bad past experiences Not sleeping for days Anxiety Paranoia/suspicion

Unusual beliefs Hearing voices/seeing things Anger control Loss of interest

What do/does you/patient do for fun/hobbies? (List):

____

Are you/patient doing the above activities at the same rate? Explain:

____

Are you/patient currently involved in a relationship? Yes / No For how long? ________________________

What current stressors are in your/patients life? Circle all that apply

Death of family Domestic violence Employment Finances

Parenting Poor social support Housing/homeless School

Divorce Sexual abuse/trauma Transportation Legal/criminal charges

SUBSTANCE ABUSE:

Have you/patient ever had an alcohol or drug problem: Yes / No

Did you/patient ever use: Circle all that apply

Marijuana Cocaine/ Crack Methamphetamine Gas/inhalants

Barbituates Mushrooms PCP LSD

Ecstasy Spice

How old were you when you first used: Alcohol _________ Marijuana ___________ Other drugs ________

List your/patient's most frequently used alcohol/drug ____________ Was it used: Daily Weekly Monthly

Circle if you had the following:

Blackouts Withdrawal Tremors Seizures Morning drinking

Have you/patient ever had a DUI/DWI or other alcohol related offense Yes / No (How many) _____________

Have you/patient ever attended substance abuse treatment: Yes / No (List how many, last)

____

____

Does you smoke cigarettes? Yes / No How many a day?__________________

How many cups of coffee/soda or energy drinks do you have daily?________________

PSYCHOSOCIAL:

Where were you/patient born ___________________ How many moves w/family from ages 0-18 __________

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Highest grade completed in school _______________ HS Diploma: Yes / No BA/BS degree: Yes / No

Last school attended, year ______________________________ Average grades/GPA in school ____________

Best academic subject for you/patient ______________ Worst academic subject for you/patient ___________

Did you/patient ever attend special education: Yes / No What subjects: Math Reading Writing All

Have you/patient ever had an IEP: (List when, what for) ____

If you/patient are currently attending school, what grade/school: _____________________________________

Were you/patient ever suspended or expelled: Yes / No What for: ____________________________________

Are you/patient currently employed: Yes / No If so, where: ____

What is the longest time you/patient has worked the same job (years) ________ Title: ___________________

What is the longest time you/patient has been unemployed: ____

Have you/patient ever served in the military: Yes / No What branch ____________ Rank at discharge ________

List all current sources of income for you/patient: ____

Have you/patient ever applied for social security disability: Yes / No If so, when last applied: _____________

Have you/patient ever been married: Yes / No If so, how many times: _________ Last marriage: __________

Do you/patient have children (List name, age, location)

List name(S):	List age(s) for all kids	List Location(s) for all Kids
1:_____________________	__________________	____________________
2: ____________________	__________________	____________________
3: ____________________	__________________	____________________
4: ____________________	__________________	____________________

LEGAL:

Have you/patient ever been arrested as a juvenile or adult: Yes / No What for:

____

If so, list first age of arrest __________, total number of arrests __________, date of most recent __________.

Are you/patient currently on probation or parole: Yes / No

Are you/patient involved in any litigation or legal proceedings with the following: Circle all that apply

Worker's comp Personal injury DFYS/OCS Divorce Child custody N/A

CURRENT LIVING SITUATION:

List all people living in your household:____

How long have you lived there: ____

REMEMBER: If you have previous school records, psychiatric evaluations, or other medical records regarding the problem you are being seen for, please bring them with you. If you/patient have any problems hearing or seeing, remember to BRING YOUR HEARING AIDS/ GLASSES. *On the day of your appointment please remember not to take any medications with sedating side effects or medications that are used to control ADHD or ADD – You may bring them with you to take after testing process.

Alaska NEURO
Associates, LLC
Comprehensive Evaluations. Relevant Recommendations.

4241 B Street, Suite 202, Anchorage, AK 99503
Phone: 907-277-0100 Fax: 907-222-0566
alaskaneuro.com

AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

Please send reports to: Alaska Neuro Associates, LLC, 4241 B Street, Suite 202, Anchorage, AK 99503
Phone: 907-277-0100 Fax: 907-222-0566

PATIENT NAME ____ DATE OF BIRTH ____________________

The purpose of obtaining/releasing information is to get a complete record of medical and developmental history. This information is essential to providing a comprehensive evaluation and to recommending appropriate services as well as to avoid unnecessary testing and duplication. If applicable records exist please complete the following sections.
The following people have been, or will be involved with my/my child's care. I authorize the mutual exchange of information between Alaska Neuro Associates - ANA and:

Please check all that apply	Please print name, phone number, and fax number of Provider	Dates Seen	Release: **From**	**To**
☐ Primary Physician	______________________________	__________	☐	☐
	______________________________	__________		
☐ Hospital Records	______________________________	__________	☐	☐
	______________________________	__________		
☐ MRI, CT scan, EEG	______________________________	__________	☐	☐
	______________________________	__________		
☐ Neurologist	______________________________	__________	☐	☐
	______________________________	__________		
☐ School Records	______________________________	__________	☐	☐
	______________________________	__________		
☐ Psychology/Counseling	______________________________	__________	☐	☐
	______________________________	__________		
☐ Speech/ Occupational Therapy	______________________________	__________	☐	☐
	______________________________	__________		
☐ Other(please specify)	______________________________	__________	☐	☐
	______________________________	__________		

☐ I give permission for the final report to be EMAILED to the following addresses: (please ask for password protected if needed, email is not secure
otherwise)____

Terms: I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my/my child's health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information. I understand that raw test data will only be released to a trained Neuropsychologist professional. This request must be in writing.
Expiration & Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Services Department. Unless revoked earlier, this authorization will expire twelve months from the date on which it was signed, or upon the following **date or event**: __________
Re-disclosure: I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

______________________________ ______________________________ ______________________________
Signature Relationship to patient Date

______________________________ ____
Please print name Address

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Alaska Neuro Associates, LLC
Notice of Privacy Practices

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. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY CONTACT, WHO IS THE OFFICE MANAGER AT 907-277-0100.

This Notice of Privacy Practices tells you how we may use and disclose your protected health information to treat you, bill for the care we provide, and operate our practice in a business–like manner. It also explains when we may use or disclose patient health information to comply with various laws. “Protected health information” (“PHI”) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices.

We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website at www.alaskaneuro.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician’s practice. Alaska Neuro Associates, LLC will limit its own uses and disclosures of PHI to the minimum amount of information necessary to accomplish the purpose at hand.

Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will also disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend and have provided for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we often are required to provide written medical documentation to support services provided to you.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use your name and address to send you a newsletter about our practice and the services we offer. We may also use your PHI to provide you with information about treatment alternatives or other health-related benefits and services that are relevant to your condition. We will, under no circumstances, sell our patient lists to any third party.

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Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures of Protected Health Information for Public Policy Purposes

We may use or disclose your PHI in the following situations:

Required By Law: We may use or disclose your PHI to the extent that such use or disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI about you in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal to the extent such disclosure is expressly authorized. We may also disclose PHI about you in response to a subpoena, discovery request or other lawful process, provided appropriate steps have been taken to notify you or to get a protective order from the court to safeguard your PHI.

Law Enforcement: We may disclose PHI for law enforcement purposes, such as: (1) legal processes and otherwise required by law, (2) pertaining to victims of a crime, (3) suspicion that death has occurred as a result of criminal conduct, (4) in the event that a crime occurs on the premises of the practice, and (5) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner, medical examiner, or funeral director for identification purposes, as appropriate.

Research: We may disclose your PHI to researchers doing studies based on existing medical records or using existing records to plan a study involving patient treatment when their research has been approved by an institutional review board, which has reviewed the research proposal and established protocols to ensure the privacy of your PHI. If you agree to participate in research involving treatment, you will also be asked to sign an authorization to allow the researcher to use PHI gathered in the study.

Imminent Threats: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military and security purposes.

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Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Disclosures to the U.S. Department of Health and Human Services: Under the law, we must make disclosures on request to the Secretary of the Department of Health and Human Services ("HHS") to help HHS determine our compliance with federal laws that protect the privacy of your health information.

Other Uses and Disclosures of Protected Health Information:

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke an authorization at any time, in writing, except to the extent that your physician or the practice has taken an action in reliance on the uses or disclosures permitted under that authorization.

2. Your Rights

You have the right to inspect and copy your PHI. You may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and/or the practice uses for making decisions about you.[1] You may be charged a fee for the copying at the rates prescribed under local law. To obtain access to your medical record, you must submit a written request for such record to the Privacy Officer.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You must submit the request in writing and describe the specific restriction requested and to whom you want the restriction to apply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of litigation, or information governed by certain federal laws pertaining to laboratory testing quality.

Your physician is not required to agree to a restriction that you may request. We may deny your request for an amendment if we believe the information at issue is accurate and complete or if we did not create the information originally. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have your physician amend your protected health information. You may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. We will not delete information from your medical record, but we may make adjustments or note corrections to the record, if so agreed. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes **other than** treatment, payment or healthcare operations, as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures

that occurred after April 13, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

[1] **Ethical Standard 9.04 "Release of Test Data"** states that "Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law."

You have the right to obtain a paper copy of this notice from us at any time.

3. Non-Standard Conditions

It is our opinion that the presence of a third party (audio- or videotaping or other non-standard condition) may not result in a statistically accurate or psychometrically sound scaled score. As you may know, norms for standardized tests are developed under strict conditions. If such conditions are not met, the scaled scores obtained by application of the test norms are not statistically defensible. Although it is the position of Pearson that the validity of any scaled score which results from a non-standard administration is suspect, it is the responsibility of the individual psychologist administering the test to determine whether testing under non-standard conditions serves any other purpose.

4. Complaints

You may complain to us or to the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650 or by emailing PrivacyOfficial@health.state.ak.us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, The Office Manager at 907-277-0100 for further information about the complaint process.

This notice was published and becomes effective on **October 1, 2010.**