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

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 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. 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 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.

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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 (Must be filled out completely for patient)

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. You are responsible for paying any balance that is not covered by your insurance. Insurance coverage is not a guarantee of payment. Please call our billing department for any questions or need assistance with a prior authorization. **Charges for a neuropsychological evaluation range from $4,600.00 - $5,200.00, and the feedback session additional $425.00**.

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.

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 at the time of service. **You are responsible for paying any balance that is not covered by your insurance.** 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 $5,000.00 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] _____

_____ _____

Patient/Responsible Party Signature Date

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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. 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 claim, 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, 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.

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 professional Neuropsychologist qualified to interpret the data. This request must be in writing.

_____
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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CHILD/FAMILY HISTORY QUESTIONNAIRE

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN FULL

DEMOGRAPHIC INFORMATION

Form completed by: _____ Relationship to child: _____
Child name: _____ Date of Birth: _____ Age: _____
Gender: M F Race/Ethnicity:_____ Primary Language: _____
Handedness: Right/Left/Both Current Grade: _____Current School: _____
Who referred you to this evaluation? _____
Who is your Pediatrician/Primary Care Provider? _____

REASON FOR REFERRAL

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

_____
_____

When did your child's problem first start? (Age) _____

How have their problems changed over time? Better Same Worse

What do <u>you</u> think is the cause of their problems?

_____

What have you tried before and how did it work?

_____

<u>Within the last 6 months, my child has had SIGNIFICANT problems with…</u>

<u>Memory</u> – they easily forget…(Circle)

Events from years ago	Names of close friends/Family	Recent conversations	Events from yesterday
Verbal directions	Information just read	Home phone numbers/Address	
Regular assignments/Chores/Medications		Where they left their stuff	

<u>Attention</u> – they struggle with… (Circle)

Finishing books/Movies	Focusing for lengthy periods	Doing two things at once	Poor attention to detail
Diagnosis of ADHD	Hyperactivity	Mind wandering	Listening (> 10 min)
Distractibility	Day dreaming at work/school	Not finishing tasks	Not turning in completed work

PATIENT PROBLEM AREAS

<u>Language</u> - they have a hard time with… (Circle)

Understanding others	Not knowing the names of things	Feels that others speak too fast
Spelling/Dyslexia	Organizing their written work	Reading comprehension

<u>Spatial Orientation</u> - they struggle with… (Circle)

Getting lost easily	Telling right from left	Having poor coordination/ being clumsy
Running into obvious objects	Learning to ride a bike	

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Processing Speed – they seem... (Circle)

Slow to complete class work | Physically slower than peers | Slow to complete chores when trying

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

Executive Functioning - they struggle with… (Circle)

Thinking logically | Planning ahead | Completing multiple-step tasks/projects
Understanding time | Impulsivity | Learning from consequences
Solving new problems | Adapting to change | Transitioning to a new activity
Understanding new situations

Mood/Behavior - on more days than not, they have problems with… (Circle)

Nervous	Worry wart	Anxiety attacks	Specific fears	Picks at self/Bites nails
Tics	Overly shy	Indecisive	Perfectionistic	Easily overwhelmed
Repetitive behavior	Feels guilty	Withdrawn	Cries easily	Suicidal
Low self-esteem	Always negative	Loss of interest	Doesn't enjoy things	Hurts self
Angry outbursts	Hopeless	Aggressive	Swearing	Lie/ Steal
Destroys things	Repetitive body movements	Hurts people/animals	Runs away	Immature
Doesn't trust others	Suspicious/Paranoid	Dwells on past trauma	Loner	Stubborn
Disrespects adults	Frequent headaches	Irritable/Upset stomach	Won't stop talking	Argumentative
Mood too "high"	Needs less sleep	Severe mood swings	Doesn't show emotion	Can't go places alone
Obsessive interest	Obsessed with weight	Sad/Down		

Really impulsive (money, sex, drinking, drugs)

Within the last month, which of the above problems is worse than the others?

_____

Social Skills - they have lots of problems with… (Circle)

Prefers younger peers | Preferring to be alone | Making friends
Personal boundaries | Eye contact | Understanding nonverbal social cues
Being "different" from peers | No sense of humor | Maintaining friendships
Bullies others | Being bullied | Lacking remorse for hurting others
Fighting with friends | Knowing how to play | Being overly demanding in relationships
Being controlling/Bossy in friendships | Being a "little adult" | "Policing" peers behavior

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Daily Living - they have lots of problems with… (Circle)

Choosing clean clothes	Brushing teeth	Using deodorant
Cleaning properly after bowel movement	Washing their body well	Needing reminders to bathe
Being aware that they smell/has bad breath	Checking their appearance	Not recognizing pain
Choosing wrong clothes for weather	Being sensitive to certain fabrics	Oversensitive to light/noise/busy environment

MEDICAL HISTORY

Pregnancy/Birth/Development:

Duration of pregnancy (weeks) _____ (Full-term is 40 weeks)

Circle any of the following problems during the pregnancy: (Please explain below)

Excessive vomiting	Infections	Threatened miscarriage	Diabetes
Toxemia	Anemia	High blood pressure	Physical Abuse
High Stress (explain)	Motor vehicle accident	Fall	Surgery

Prenatal exposure to: Cigarettes Alcohol Drugs (cocaine, meth, marijuana, spice, etc.)

Explanations:

_____

_____

Medications taken during pregnancy (over-the-counter and prescriptions):

_____

Other significant events, complications, medical procedures during pregnancy:

_____

_____

Duration of Labor: _____ Breech position: Yes / No

Apgar scores (if known) _____ Birth weight: _____ pounds _____ ounces

Complications: "Blue" Baby Cord around neck Hemorrhage Suction

Required: Oxygen Transfusions Treatment for jaundice

Other complications (i.e. infections, birth defects, injury): _____

NICU or Specialized care (incubator, oxygen tent, etc): Yes / No _____

If yes, number of days: _____

Number of days your child was in the hospital after delivery: _____

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As a baby, did your child have problems with? Circle all that apply:

Sucking/Swallowing/Feeding	Heart rate	Breathing	Sleep apnea
Sleeping problems	Allergies	Didn't like being held	Limp
Unusually small/Not Growing	Colic	Not responsive to touch, sound, etc.	

Describe your child's behavior and mood during their first 2 years of life:

_____

Developmental Milestones (Months):

_____ First words	_____ Sentences (3 words or more)	
_____ Sat up	_____ Crawled	_____ Walked
_____ Bladder trained (day)	_____ Bladder trained (night)	_____ Bowel trained

Does your child have ongoing bladder <u>OR</u> bowel accidents: Yes / No How often? _____

<u>Medical Problems from Birth through 6 Years Old</u>:

Grew slowly/Underweight	Ear infections	Tubes in ears	High fevers
Many headaches	Many stomach aches	Staring spells	

Explain:

_____

_____

Any overnight medical hospitalizations?

_____

_____

<u>Behavior Problems from Birth Through 6 Years Old:</u>

Hyperactive	Aggressive	Difficult to calm	Extreme tantrums
Overly sensitive to sound/touch	Stiff when held	Severe separation anxiety	Played alone

If female, age at first period: _____ Regular periods every month? Yes / No

Is there severe pain and changes to mood/behavior with periods? Yes / No

<u>Head Injury:</u>

Has your child ever had a serious hit to the head that resulted in any of the following problems?

Yes/No If yes, explain:

Headache	Sleeping too much	Fatigue	Difficulty concentrating
Feeling dizzy	Vomiting	Memory problems	Feeling foggy

_____

_____

How many times? _____ What age at each time? _____

Did your child ever have a loss of consciousness (been knocked out)? Yes / No

How many times? _____ What age at each time? _____

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CURRENT MEDICAL INFORMATION

Height: _____ **Weight:** _____

List all medical problems:

_____

_____

Does your child require glasses? Yes / No

Ongoing vision problems even with glasses/contacts? Yes / No

Does your child have a hearing impairment? Yes / No **Hearing aid?** Yes / No

Has your child had any of these medical issues? (Circle)

GERD	Cancer	Chronic asthma	Exercise induced asthma	Sleep apnea
Diabetes	Hearing loss	Ulcers	Epilepsy/Seizure	Severe or frequent headache
Thyroid problems	Tics/Twitch	Fainting	Loss of bladder/bowel control	

Does your child complain a lot about pain in any particular area? Yes / No _____

Any idea why? _____

Sleep Problems:

Typical bedtime: _____ **Typically awake at:** _____

How long does it take for him/her to fall asleep? _____

Hours of sleep per night? _____

History of sleep study? Yes / No **Where was study performed**?_____ **When?**_____

Tonsils and/or adenoids removed? Yes / No **Sleep better after?** Yes / No

Any of the following: (Circle)

Fearful of the dark	Grinding teeth	Falling asleep at school
Sleep walking	Sleep talking	Can't wake up in morning
Frequent awakenings	Napping regularly after school	Excessive daytime sleepiness
Nightmares	Loud, constant snoring (not just when ill)	Can't get going in mornings
Restlessness/Twitching during sleep		

Any of the following in child's room? (Circle)

TV/Cable	Computer	iPad	DS/Nintendo	Kindle
Cell Phone/Phone	DVD Player			

Appetite: (Circle)

Recent weight gain/loss	Hiding/Hoarding food	Food can't touch/mix on plate
Binge eating	Noticeable appetite increase/decrease	Over picky eater
Chronically hungry (even if just ate)	Recognize when full	

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Food rejected due to: (Circle)

Texture in mouth "Looks different"

Please list your child's most recent outpatient visit (Provider name, reason for visit):

_____

Current medications:

Drug Name:	**Dosage:**	**Prescribing Doctor:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you think these are helping? (Circle one)

"No" "A little" "Pretty good" "Huge improvement"

Over-the-counter medications, herbal remedies, supplements, vitamins:

_____

FAMILY/MEDICAL HISTORY

Biological mother's education: _____ Employment: _____

Biological father's education: _____ Employment: _____

Has your child's biological *parents or siblings* had problems with any of the following?

Bipolar	Depression	Anxiety	OCD	Completed suicide
MR	Autism/Asperger's	Learning disorder	ADHD	Sleeping disorders
Schizophrenia	Thought disorder	Antisocial traits	Alcoholism	Drug abuse
Dementia	Seizures	Diabetes	FASD	PTSD
Chronic pain	Other: _____			

Do your child's problems remind you of anyone else in the family (aunts, uncles, grandparents, etc)? Yes / No

If so, who? _____ What was their diagnosis? _____

How are they alike? _____ How are they different? _____

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PSYCHIATRIC HISTORY

Abuse:

Any history of abuse or trauma? Yes No

Physical	Sexual	Emotional	Left Alone
Didn't have enough to eat/drink	Had to take care of siblings	Didn't have proper clothing	Seen violence between family members
Left with strangers/others	Had to take care of parent as child		Often saw parents drunk/high

Treatment:

Has your child ever been psychiatrically hospitalized or in a Residential Treatment Center?

Yes / No **Which one? _____ For how long? _____**

Was this helpful? Yes / No **Why/Why Not? _____**

Age at first admission? _____How many total admissions/residential placements (estimate)? __

Date of most recent admission? _____ For what? _____

When did you first seek help for your child's mental health problems? _____

Was this from a… family/medical doctor **OR** a psychiatrist/counselor/therapist

For what? _____

Age when first put on medication:_____ What was it? _____ Did it work? Yes / No

List ALL psychiatric diagnosis: _____

_____

Is your child receiving therapy (individual or group) now? Yes / No

If Yes, with who? _____ Is it working? _____

Is your child taking psychiatric medications now? Yes / No

If Yes, name of medication(s): _____

Is it working? Yes / No

Severe Symptoms:

Has your child ever hurt themselves on purpose? Yes / No **By doing what? _____**

First time: _____ Last time: _____Total number of times: _____

Any history of:

Cutting self	Burning self	Hitting self
Scratching at skin	Pulling out hair	Banging head
Talking about suicide	Wishing to be dead	Wanting to "go away"

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Has your child ever threatened to hurt themselves? Yes / No

If yes, how (i.e. holding a knife to themselves)? _____

What current stressors are in your child's life? (Circle)

Death of family	Addition to family	Family finances
No support	Legal/Criminal charge	School
Divorce//Separation	Relocation	No friends
Family injury/illness		

Other: _____

SUBSTANCE USE/ABUSE HISTORY

Has your child ever tried/used: (Circle) – **If NO move to Psychosocial History**

Marijuana	Cocaine/Crack	Meth	Gas/inhalants	Pain pills/Sedatives
Mushrooms	Spice	LSD	Ecstasy	Alcohol

How old was your child when he/she first used:

Alcohol _____ Marijuana _____ Other drugs _____

List your child's most frequently used drug: _____

How often? Daily Weekly Monthly

Circle if your child has ever had the following from drug or alcohol use:

Blackouts Withdrawal Tremors Seizures Morning drinking

Has your child ever had a MCA or other alcohol related arrest? Yes / No

If yes, how many? _____

Has your child ever gone to inpatient treatment or community programs for substance abuse? Yes / No **If Yes, list how many total and last:** _____

Does your child smoke cigarettes? Yes / No **How many a day?** _____

How many cups of coffee/soda or energy drinks does your child have daily?_____

PSYCHOSOCIAL HISTORY

Family Information:

Who does your child live with?

Biological Family Adoptive Family Foster Family RTC Other_____

List all members of current home, including foster family members:

_____

_____

Biological parent's divorced? Yes / No **When?** _____

Remarried? Yes / No **Number of times:** _____

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Who has custody? _____

Step-Father's Name: _____ **Step-Mother's Name:** _____

How much contact/Relationship with biological mother: _____

How much contact/Relationship with biological father: _____

If parents are deceased, what from? Father: _____ Mother: _____

Where was your child born? _____ **How many moves w/family from ages 0-18?** ___

In OCS custody? Yes / No **Case worker:** _____ **Telephone #:** _____

Parental rights terminated? Yes / No **Date of termination:** _____

Adopted? Yes / No **When?** _____

Foster/Adoptive parents occupations: _____

Caretakers in early life (if different from now): _____

How does child get along with parents/caretakers? _____

List child's biological brothers _____ **sisters** _____

What is child's birth order (e.g., 3rd): _____ **Ages of siblings:** _____

How does child get along with siblings? _____

Describe the mood of your child's home: _____

Discipline in the family:

Who does most of the discipline? _____ Consistent between parents? _____

What approach do you use? _____

Does this work? _____

What chores or responsibilities does your child regularly do?

_____

Does your child have regular scheduled homework hours? Yes / No

Does your family have a good support network? Yes / No **Describe**:

_____

Entertainment choices (hours spent per day):
TV: _____ Video games: _____ Computer: _____ Reading: _____
What does your family do together for fun? How often?

_____

School Information:

Current grade: _____ **Current School:** _____ **Current teacher:** _____

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Last three schools attended and dates:

_____

_____

Highest grade completed in school: _____ **Average grades/GPA:** _____

Did your child ever need special education? Yes / No **Current IEP or 504?** Yes / No

Does your child need help with: Math Reading Writing All Other: _____

Has your child ever repeated a grade? Yes / No **What grade(s):** _____

Was your child ever suspended or expelled? Yes / No **How many times total?** _____

What for? _____

Has your child's classroom teacher(s) reported any of the problems below? (Circle)

Attention/Concentration	Social problems	Poor memory
Distractibility	Withdrawal	Not following directions
Hyperactivity	Aggression	Poor handwriting
Not turning in assignments	Learning/Academic problems	Daydreaming
Behavior problems	Blank staring	

Does your child participate in school sports or other school related activities? Yes / No

If so, what are they? _____

Employment/Financial

Is your child currently employed: Yes / No **Where/Job title:** _____

What is the longest length of employment for your child (months)? _____

List all current sources of income for family: _____

Has your child received social security disability? Yes / No **Was it awarded?** Yes / No

If so, when last applied? _____ **For what?** _____

Legal:

Has your child ever been arrested or detained by the police? Yes / No **What for?** _____

Age at 1st arrest: _____**Total number of arrests:** _____**Date of most recent:** _____

Is your child currently on probation or parole? Yes / No

Has your child ever run away from home? _____ **How many times?** _____

Is your family/child involved in any open litigation or legal proceedings with the following?

Worker's Compensation Personal Injury DFYS/OCS Divorce Custody

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REMEMBER: Bring records from schools, hospitals, psychiatrists, psychologists, CT/MRI scans, and testing regarding your child's problem(s).

ALSO BRING THEIR HEARING AIDS, GLASSES, AND SNACKS!

Additional Information

Please include any other information that will help us better understand your child's problem.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.**

Thank you for taking the time to complete this questionnaire!

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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. 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.

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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.

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.

[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."

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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.

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.**