Neuropsychology Associates of North Texas

Michelle L. Bengtson, Ph.D.
1340 N. White Chapel Blvd., Suite 130
Southlake, TX 76092
P: 817-251-0911 F: 817-416-2731

Welcome!

We are glad you have chosen Neuropsychology Associates of North Texas and we look forward to serving you. The following pages are our patient information and history forms. Please try to be as detailed as possible when filling out the forms. The more information Dr. Bengtson has the better. After the patient forms are several disclosure and consent forms. Please sign these and return them with the patient forms. Upon completion, you may forward the packet to our office by either:

Mailing to:

1340 N White Chapel, Blvd, Suite 130
Southlake, TX 76092

Faxing to: **817-416-2731**

Emailing to: **drbengtson@texnant.com**

The sooner these forms are completed the sooner Dr. Bengtson will be able to review your information for your appointment. Also, completing and returning the packet quickly makes it much easier for us to move up your appointment if an earlier time becomes available.

Please let us know if you have any questions, the office number is: **817-251-0911**.

We look forward to meeting you!

Neuropsychology Associates of North Texas

Patient Information Form

Today's date: _____ **MRN:** _____ **Interviewer:**_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name:_____
Date of birth: _____ Age: _____ Social Security #: _____
Home street address: _____ Apt.:_____
City: _____ State: _____ Zip: _____
Home/evening phone: _____ Work phone: _____ Other phone:_____
Insurance Company: _____ Policy #: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? □ Yes □ No
How did this person explain how I might be of help to you? _____
_____
_____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? □ Yes □ No

D. Your current employer

Employer:_____Occupation:_____
Address: _____

E. Your education and training

Dates From	To	School	Major	Special Classes?	Usual Grade?	Did You graduate?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Ever repeat a grade? _____

(cont.)

F. Employment and military experiences

Dates From	To	Name of military or employers	Job title or duties	Reason for Leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

For military service history: Combat experience? Y/N Highest rank:_____ Discharge Type:_____

G. Family-of-origin history

Relative	Name	Current age/ (age deceased)	Illness (or cause of death, if deceased)	Education	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

H. Marital/relationship history

Current Marital Status: Single _____ Separated _____ Married _____ Divorced _____ Widowed _____

Spouse's name		Your age at marriage	Spouse's age at marriage	Spouse's Education	# Years Married	#Children	Is spouse remarried?
First	_____	_____	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____	_____	_____

I. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Age	Sex	School	Grade	Adjustment problems?	P?
_____	_____	_____	_____	_____	_____	__
_____	_____	_____	_____	_____	_____	__
_____	_____	_____	_____	_____	_____	__
_____	_____	_____	_____	_____	_____	__
_____	_____	_____	_____	_____	_____	__

J. Medical History (indicate any history of present and past serious illness, accidents, injuries and treatment)

Present/past illnesses,diseases, syndromes	Dates of illness	Treatment/surgery/medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past accidents leading to injury	Dates	Treatment/surgery/medication
_____	_____	_____
_____	_____	_____

Surgeries/Hospitalizations	Dates	Reason
_____	_____	_____
_____	_____	_____

(cont.)

K. Chief Concern (indicate what difficulties, symptoms or complaints led to your referral here)

_____
_____
_____
_____

L. Review of Current/Recent Symptoms (indicate which of the following symptoms you have experienced in the past **12 months**)

Loss of Consciousness	Yes	No	Decreased Happiness	Yes	No
Memory Difficulties	Yes	No	Decreased Motivation	Yes	No
Weight Changes	Yes	No	Decreased Energy	Yes	No
Chronic Pain	Yes	No	Sleep Difficulties	Yes	No
Feeling Shaky	Yes	No	Social Isolation/Withdrawal	Yes	No
Blurred/Double Vision	Yes	No	Frequent Anxiety/Worry	Yes	No
Change in ability to smell	Yes	No	Depressed Mood	Yes	No
Chronic ringing in ears	Yes	No	Anger Outbursts	Yes	No
Muscle jerks or twitches	Yes	No	Unusual/Frightening Thoughts	Yes	No
Bowel or Bladder Problems	Yes	No	Feelings of Paranoia	Yes	No
Speech Difficulties	Yes	No	Frequent Headaches	Yes	No
High Fever	Yes	No	Dizziness	Yes	No
Allergies	Yes	No	Nightmares	Yes	No
Seizures	Yes	No	Flashbacks	Yes	No

M. Psychological History (please indicate any past or present treatment for psychological difficulties)

_____
_____
_____
_____

Current or past medications: _____

N. Family Psychological History (please indicate your relationship to any family members who have received psychiatric treatment or treatment for drug or alcohol problems)

Relationship	Problem	Type of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

O. Substance History

Do you currently smoke? Yes No
If you smoked previously, when did you stop? _____ Years smoked? _____ How much? _____
Do you currently drink? Yes No
How much do you drink? _____ What type of alcohol do you drink? _____
Do you use recreational drugs? Yes No If yes, what kind and how much? _____

P. Financial/Legal History

Are you currently involved in any legal proceedings? Yes No If yes, describe:_____
Have you ever been convicted of a felony or misdemeanor? Yes No If yes, describe:_____
Have you ever been in jail? Yes No If yes, describe: _____
Do you currently hold a driver's license? Yes No If yes, are you currently driving? Yes No
Have you ever been convicted of a DUI? Yes No
Are you currently receiving any type of disability income? Yes No
Are you currently in the process of applying for disability income (e.g. SSI)? Yes No

Q. Additional Information (please indicate any other information you feel is important for me to know)

_____
_____
_____

Neuropsychology Associates of North Texas

Adult Checklist of Concerns

Name:_____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains

(cont.)

- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

- ☐ _____
- ☐ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____

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FINANCIAL AND DISCLOSURE ACKNOWLEDGEMENT

Release of Information: I consent and authorize Neuropsychology Associates of North Texas, P.A. (hereinafter referred to as "NANT") and any practitioner providing psychological services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at NANT or by any practitioner providing services to patient, including, but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records, medical history, treatment progress, and/or any other such related information to: (1) Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors; (2) Medicare: (3) Medicaid; (4) any other person or entity that may be responsible for paying or processing for payment any portion of my NANT bill or conducting utilization management/review and financial/medical audits; (5) to any person or entity affiliated with or representing NANT and any practitioner providing medical goods and services to patient for the purpose of administration, billing, and quality and risk management; (6) to any other hospital, nursing home, or other healthcare institution to which patient is transferred; (7) patient's primary, attending, consulting, referral, and/or family physician for follow up, physician information and/or continuity or care to include prospective or current home health company, to referring facility health care staff or to NANT; (8) any authorized representative for the purposes of conducting patient satisfaction surveys; (9) affiliated follow up programs; or (10) patient tracking boards with information to facilitate treatment. I authorize NANT to release any information/records and make such reports regarding patient's care and health status as may be required by law or regulation. I give permission for the release of information to be transmitted by U.S. Mail, facsimile, or other electronic medium. This consent to disclosure applies to any and all of the patient's subsequent contacts with NANT. This consent to release medical information is subject to revocation in writing at anytime, except that action has been taken.

ASSIGNMENT OF BENEFITS/INSURANCE REQUIREMENTS: In consideration of goods and services rendered, I irrevocably assign and transfer to NANT all right, title and interest in all benefits/monies payable for goods and services including, but not limited to, group medical/indemnity/ERISA benefits/coverage, PIP, UIM/UM, auto/homeowner insurance, and in all causes or action against any party that may be responsible for payment, and the right to any and all claims, demands, suits, remedies, guarantees and liens. I understand that in the event NANT files a claim on my behalf that the same does not impose any obligation upon NANT and that I remain responsible for instituting suit or appealing within the applicable limitations period. It is agreed that any condition, including, but not limited to, pre-certification, pre-authorization, or second opinions shall remain the sole responsibility of patient and/or the patient's representative. I agree that failure to pre-certify could result in reduced payment(s), leaving the undersigned financially responsible. It is agreed that the obtaining of verification of benefits and/or pre-certification does not relieve patient or patient's family, other individual or entity signing on behalf of patient of any liability for the financial responsibility for goods and services provided by NANT. In the event patient is entitled to benefits for psychologists goods and services, these benefits are hereby irrevocably assigned to the psychologist(s) providing such goods and services.. I authorize that the payors listed herein and any other payors may release any and all information requested and/or related to my claims to NANT and/or its attorneys. This authorization is irrevocable upon execution by me, and any appeal or suit brought by NANT shall be as if it was brought by me personally.

FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to patient, the undersigned, whether he/she is the patient, patient's relative, patient's legal guardian, representative, agent, other individual or entity, hereby obligates himself/herself individually, to NANT psychologists involved in patient's care and agrees to pay for all charges incurred. It is agreed that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges for services rendered, and I agree that all amounts are due upon request and are payable to NANT, and agree to pay for all charges incurred. It is agreed that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I, as the designated responsible party or entity, shall pay all collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Signature of Patient, if adult, or Patient's Parent/Legal Representative	Relationship
Patient's Name (Printed)	Date of Birth
Witness	Date

Neuropsychology Associates of North Texas

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CONSENT FOR TREATMENT

The undersigned consents to any evaluation or therapy rendered to the patient by staff at Neuropsychology Associates of North Texas, P.A., which, in the judgment of such practitioners, is advisable during the course of diagnosis and treatment.

The undersigned certifies that he/she has read the foregoing, and is the patient or parent of the patient or the legally authorized representative of the patient.

_____ _____
Name & Relationship to Patient Date

_____ _____
Patient's Name Date of Birth

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POLICIES REGARDING PAYMENT OF SERVICES

Insurance

We will contact your insurance company on your behalf for precertification and verification of benefits. We will verify your deductible amount and what portion of the deductible has been met as well as any portion that you may be responsible for in regard to your visit and any psychological or neuropsychological testing. Once we have obtained this information we will either contact you by phone, e-mail, or letter to inform you of the amount you will need to pay prior to your visit.

Please be advised that verification of benefits does not guarantee claim payment and a final coverage determination can not be made until your insurance company receives a claim for examination. This disclaimer is provided to advise you, that if your insurance company deems your claim not medically necessary or does not pay the entire amount of the claim, you will be solely responsible for payment of the claim.

We will estimate the patient responsibility to the best of our ability. Estimated charges could differ based upon the actual tests given by Dr. Bengtson during the visit. In the event the estimated charges differ from the actual charges, a statement for those charges will be billed to you once the insurance has paid.

It is the policy of Neuropsychology Associates of North Texas to collect copay, deductible or patient percentages prior to any office visit.

Returned Check Policy

Please be aware there will be a $50.00 fee for all returned checks. Until payment is received in cash, by credit card or money order, no further appointments will be scheduled.

Cancellation Policy

If for some reason you are unable to make your scheduled appointment time, we require a 24-hour advance notice by telephone. Our office voice mail is always on to take your call and has a date/time stamp for all messages.

Patients who "no show" for appointments or cancel without a 24-hour notice will be billed a $185.00 cancellation fee. This fee must be paid before any other appointments are scheduled. Please remember this could cause your next appointment to be days or weeks from your original appointment date.

By signing this form, I understand and agree to abide by any and all policies with regards to any and all services provided by Dr. Michelle L. Bengtson and /or Neuropsychology Associates of North Texas, P.A.

_____ _____

Print Patient's Name **Date of Birth**

_____ _____

Signature & Relationship to Patient **Date**

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NOTICE OF PRIVACY PRACTICES

(Brief Version)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP. If you would like to read the full version, please ask our Privacy Officer and they will provide you a copy. However, we can not cover all possible situations so please talk to our Privacy Officer about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization, which is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which do not happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private to you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. (address below) All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at:

Neuropsychology Associates of North Texas, P.A.
c/o Privacy Officer
1340 N. White Chapel Blvd. Suite 130
Southlake, TX 76092
phone: 817-251-0911

U.S. Dept. of Health and Human Services
HIPAA Complaint
7500 Security Boulevard, C5-24-04
Baltimore, MD 21244

This notice is effective as of August 1, 2003.

Neuropsychology Associates of North Texas

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, the patient or guardian, and Michelle L. Bengtson, Ph.D. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here _____ (patient's name).

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you may get a copy from our privacy officer or by calling us at 817-251-0911.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his/her personal representative Date

_____ _____
Printed name of Personal Representative (if applicable) Relationship to client

_____ _____
Printed Patient's Name Patient's Date of Birth

_____
Signature of authorized representative of this office
Date of NPP _____ € Copy given to client/parent/personal representative.