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

Child Development History Record

Today's date: ______________________________ **MRN:** _____________________ **Interviewer:**_______

A. Identifications

1. Child's name: _________________________________ Birthdate: ________ Age: _____ Grade: ________
Person(s) completing this form: ____________________________________ Relationship: _______________
Insured's Name: ____ Social Security #: _________________
Insurance Company: _______________________________________ Policy #: _________________________

2. Mother's name: ______________________ Age: ____ Education:________ Home phone: ____________
Address: ____
Currently employed: No Yes, as: ___________________________ Work phone: ___________________

3. Father's name: _______________________ Age: ____ Education:________ Home phone: ___________
Address: ____
Currently employed: No Yes, as: ________________________________ Work phone: ______________

4. Parents are currently Married Divorced Remarried Never married Other:_________________
Child's custodian/guardian is:____
Visitation arrangements: ____

5. Stepparent's name: ____________________ Age:____ Education:________ Home phone: ___________
Address: ____
Currently employed: No Yes, as: ________________________ Work phone: ______________________

6. Other members of household:

Name	Relationship	Age	Education	Occupation

7. Other family members not living in household:

Name	Relationship	Age	Education	Occupation

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/your child? _________________________________
____
____

C. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery

Was the child adopted? Yes No If yes, at what age? _______

Was the pregnancy planned? Yes No Was the pregnancy desired? Yes No

Please circle any of the complications experienced by the child's mother during pregnancy:

Infections	High Fever	Chemical Exposure	Vaginal Bleeding
Accidents/falls	Anemia	Nausea/vomiting	Lack of fetal movement
Seizures	Large weight gain	Weight Loss	High blood pressure
Toxemia	Urinary problems	Kidney disease	Gestational diabetes
Preclampsia	Measles/Chicken Pox	Rh/blood problems	Early Contractions
X-rays	Alcohol ingestion	Drug usage	Tobacco usage

Medications taken by mother during pregnancy:____

Healthcare received during pregnancy: ____

Was the child Full-term? Yes No If no, how many weeks premature? _____

Birth Weight: _________ Birth Length: ________

Medical complications at birth or soon after delivery? (e.g. long labor, blue baby, cord around neck, etc.)

____

____

Was labor induced?	Yes	No	Was anesthesia used during delivery?	Yes	No
Were forceps used during delivery?	Yes	No	Did the baby have meconium staining?	Yes	No
Was the baby jaundiced?	Yes	No	Did the baby require oxygen?	Yes	No
Was the baby in intensive care?	Yes	No	How long was the baby in the hospital? __________		

2. The first few months of life

Was the baby Breast-fed?	Yes	No	If so, for how long?___________________________		
Was the child a cuddly baby?	Yes	No	Was the child an irritable/colicky baby?	Yes	No

3. Developmental Milestones: At what age did this child do each of these?

Sat without support: _____________	Crawled: ______________	Walked alone:____________
Drank from cup: ______________	Fed self: ______________	Dressed self: ____________
Spoke single words:______________	Sentences: ____________	Toilet trained: ____________

Which best describes your child's development: ______Slow

_____Normal _____Fast

What is your opinion of your child's intelligence: ____Below Average ____Average ____Above Average

D. Health

Child's 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

Please indicate any history of present and past serious illness, accidents, injuries and treatment:

Sleep Problems	Yes	No	Headaches	Yes	No	Meningitus	Yes	No
Eating Problems	Yes	No	Staring Spells	Yes	No	Encephalitis	Yes	No
Ear Infections	Yes	No	Fainting Spells	Yes	No	Head Injuries	Yes	No
Respiratory Problems	Yes	No	Convulsions	Yes	No	Loss of Consciousness	Yes	No
Hearing Problems	Yes	No	Speech problems	Yes	No	Vision Problems	Yes	No

Neuropsychology Associates of North Texas

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

Past accidents leading to injury	Dates	Treatment/surgery/medication
______________________	________	______________________
______________________	________	______________________

Surgeries/Hospitalizations	Dates	Reason
______________________	________	______________________
______________________	________	______________________

E. Educational History

Name of Present School__________________________ School District_______________________ Grade_____

May I call and discuss your child with the current teacher? Yes No Teacher's name: _________________

Phone: __________________ Address: ____

Has your child ever been enrolled in special education, learning disability classes, or received academic accommodations?
Yes No If yes, please describe:____

____

Has your child ever repeated a grade? Yes No If yes, which grades: _______________________________

Is your child currently experiencing any difficulty in school? Yes No
If yes, please describe: ____

Has your child previously taken intelligence, achievement, or neuropsychological tests? Yes No
If yes, please describe: ____

F. Social Development

1. Does the child have trouble relating with (check all that apply)
children of own age?_____ teachers?_____ brothers/sisters?_____ parents?_____ other adults?_____
2. Does the child like to play with: same age children?_____ younger children?_____ older children?____
3. Does the child have: many friends? _____ few friends? _____ no friends? _____
4. How would you describe the child? A leader? _____ A follower? _____ A loner? _____
5. Has the child ever had problems involving the police or juvenile authorities? Yes No
   If yes, when and for what? ____
6. Child's religion: ______________ Attends church: regularly ____ occasionally ____ seldom ____ never ____

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

____
____
____
____

Please indicate which, if any, of the following family problems may be affecting your child:

Recent or Multiple Moves	Yes	No	Health Problems	Yes	No
Parental Separation/Divorce	Yes	No	Family Violence	Yes	No
Conflict between Parents	Yes	No	Death in family	Yes	No
Remarriage or new partner	Yes	No	Financial stresses	Yes	No
Custody Dispute	Yes	No	Absence of Parent	Yes	No
Drug or alcohol abuse	Yes	No	Family Psychiatric Illness	Yes	No

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

Symptom			Symptom		
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
Mental Confusion	Yes	No	Hyperactive Behavior	Yes	No
Poor Motor Coordination	Yes	No	Impulsive Behavior	Yes	No
Compulsive Behavior	Yes	No	Aggressive Behavior	Yes	No
Learning Problems	Yes	No	Tantrums	Yes	No

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

____
____
____
____

Current or past medications: ____

J. 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

K. Family Medical History

Please indicate if the child's parents, brothers, sisters, or any other relatives have had any of the following conditions:

Known genetic conditions or chromosomal abnormalities (e.g. Down Syndrome) Yes No

Condition			Condition		
Birth defects (e.g. spina bifida, heart defects)	Yes	No	Blindness	Yes	No
Hydrocephalus ("water on the brain")	Yes	No	Deafness	Yes	No
Mental Retardation	Yes	No	Lung Disease	Yes	No
Learning Problems	Yes	No	Heart Disease	Yes	No
Speech/Language problems	Yes	No	Diabetes	Yes	No
Blood Disorders (e.g. sickle cell disease)	Yes	No	Cancer	Yes	No
Neurological Disorders	Yes	No	High blood Pressure	Yes	No
Seizures, epilepsy, convulsions	Yes	No	ADHD/learning probs.	Yes	No
Depression/Suicide	Yes	No	Alcohol/drug use	Yes	No
Anxiety/excessive worry	Yes	No	Panic Attacks	Yes	No
Obsessive Compulsive Symptoms	Yes	No	Schizophrenia	Yes	No
Problems with the law	Yes	No			

L. Activities

What chores does your child perform around the house? ____
____

List your child's favorite activities (e.g. hobbies, sports; recreational, TV, and toy preferences; etc.):
____
____

How does your child get along with same aged peers? ____
____

How would you characterize your child? ____
____
____

How would you describe your typical approach to discipline and child behavior management:
____
____

What form of discipline do you find least effective with your child? ________________________________
____

What form of discipline do you find most effective with your child? ________________________________
____

M. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?
____
____
____
____

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

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

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

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

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

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

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**

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

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

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

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.