NEUROPSYCHOLOGY ASSOCIATES, P.A.

Welcome to Neuropsychology Associates. Since many parents are unsure of what to expect from an evaluation, we want to take this opportunity to provide you with some background about what we do, what your role is in the evaluation process, and how you can help prepare for your upcoming appointment. **Please read this information and call us at 701-297-7588 if you have any questions.**

……

Appointment Date/Time*:	
Location:	1220 Main Avenue Suite 100 Fargo, ND 58103
What to Bring to your Appointment:	Insurance information

**** As a new patient, please arrive 15 minutes early to allow for registration, copying of insurance information, & so a chart can be created for you.***

……

About Pediatric Neuropsychology

Pediatric neuropsychology is the study of how brain development is related to cognitive skills (thinking) and behavior in children. Common referral problems include difficulties with learning and memory, trouble paying attention, delays in motor or speech development, trouble with problem solving skills, or social problems. Sometimes these problems are related to a known or suspected medical problem (e.g. head injury, chromosomal disorder, seizures) and sometimes the reasons for a child's problems are not clear.

The Evaluation Process

Consultation. The first step in the process is for the child and parent(s)/guardian(s) to meet with Dr. Meidinger. **This appointment will last about 60-90 minutes**. Dr. Meidinger will ask questions about the problems that the child is having, what has been done to address these concerns so far, and obtain details regarding medical, mental health, and academic history to better understand the current issues. It is also an opportunity to interact with your child and observe his/her behavior.

Please send the following documents/records to Dr. Meidinger for her review *prior to your consultation appointment* (unless otherwise instructed by clinic staff):

- **New Patient Questionnaire.** Providing this information will allow Dr. Meidinger to focus on details during the consultation that will help address your child's specific problem(s).
- **Prior assessment reports.** This may include reports from: psychological or neuropsychological testing, cognitive testing conducted by the school, physical or occupational therapy assessment, speech-language therapy assessment, or developmental optometry assessment.
- **Pertinent medical records.** In the case of a neurological injury or illness, birth trauma, or other medical event/condition, records pertaining to diagnosis and treatment, head imaging, EEG studies, genetics

testing, or other pertinent records may be helpful as well. *Staff will provide instruction at the time of scheduling the consultation appointment about what to provide, but if you have any questions as to what to include please do not hesitate to contact us at 701-297-7588 for clarification.*

- **Academic records.** Please include a copy of your child's IEP (along with reports regarding any testing conducted at school). Sometimes report cards can be helpful. If you have concerns about reading and spelling problems, work samples are often useful (staff can advise on how to select samples).

Testing/Assessment. If warranted, Dr. Meidinger will recommend that your child undergo neuropsychological testing. *Testing is scheduled for a different day than the consultation appointment* except in circumstances in which the need for testing is clearly identified in advance of consultation, lengthy travel is required, and insurance preauthorization is not required. Testing involves giving your child a variety of tasks to assess intellectual abilities, academic skills, memory, language, problem solving, and other skills. The tests include paper and pencil tasks, looking at pictures, answering questions, and putting blocks and puzzles together.

Results/Feedback. About 2-3 weeks after testing, there will be an informing session to discuss results, diagnostic impression, and recommendations.

Confidentiality

All information disclosed during the evaluation process (interview, review of records, testing, etc.) will be kept confidential as required by North Dakota state law, the Federal Health Insurance Portability and Accountability Act (HIPAA), and ethical guidelines outlined by the state of North Dakota and the American Psychological Association Ethical Principles for Psychologists. The exceptions to confidentiality include (1) if a patient is threatening death or serious bodily harm to another, (2) if there is reasonable cause to suspect a patient or parent is abusing or neglecting a child or vulnerable adult, and (3) if there is cause to believe the child is in imminent danger of harming him/herself.

We look forward to meeting you. If we can offer clarification or assist in any way, please do not hesitate to contact us.

Dr. Meidinger & the staff
of Neuropsychology Associates

If you are unable to keep your appointment time, kindly give us 48 hours notice so that we may accommodate another patient/family.

NEUROPSYCHOLOGY ASSOCIATES, P.A. Chart#:_____

PATIENT INFORMATION:

Last Name:_____Maiden Name:_____First Name:_____M.I. ____

Address:_____
Street City State Zip County

Home Phone#: _____Work Phone#: _____ Cell Phone#: _____

Email address: _____

(Circle one) Sex: **M F** (circle one) **Marital Status**: **S M W D** Spouse's Name: _____

Patient's Social Security#: _____ Patient's Date of Birth: _____

Referring Doctor: _____

Primary Care Physician: _____

PERSON RESPONSIBLE FOR BILL:

Guarantor's Last Name: _____ Guarantor's First Name: _____

Relationship to Patient: _____ Social Security#: _____ Date of Birth: _____

Address: _____
Street City State Zip County

Home Phone#: _____ Work Phone#: _____ Other#: _____

Employer Name: _____ Address: _____

INSURANCE INFORMATION:

1st Insurance: _____ Policy Holder/Subscriber's Name: _____
Policy#: _____ Group#: _____
2nd Insurance: _____ Policy Holder/Subscriber's Name: _____
Policy#: _____ Group#: _____

MEDICARE PATIENTS PLEASE READ AND SIGN

Medicare #: _____ Supplemental Insurance: _____
Policy #: _____ Address: _____
Are you or your spouse currently working? Yes No If yes, is Medicare Primary? Yes No
I request payment of authorized Medigap benefits be made on my behalf to Neuropsychological Associates for services furnished to me by them. I authorize any holder of medical information about me to release to:_____ (Medigap Insurer). Any information needed to determine these benefits on the benefits payable for related services.
Patient's Signature: _____ Date: _____

WORKERS COMPENSATION: _____ Date of Injury: _____
Name of Insurance Carrier: _____ Claim#: _____
Address: _____ Phone#: _____
Street City State Zip

IF ACCIDENT RELATED:

Name of Responsible Ins. Co. _____ Phone#: _____
Address: _____ Date of Injury: _____
Policy Holder Name: _____ Policy#: _____

IMPORTANT INFORMATION…READ CAREFULLY

1. I authorize NEUROPSYCHOLOGY ASSOCIATES, P.A. to release medical and other information concerning this of related claims to government agencies including Social Security Administration and its intermediaries, insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize NEUROPSYCHOLOGICAL ASSOCIATES, P.A. to release medical records and billing information to my primary care and referring physician.
3. I authorize my insurance benefits to be paid to NEUROPSYCHOLOGY ASSOCIATES, P.A.
4. If a requested insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept the responsibility for collection of your insurance claim or for negotiating settlement on disputed claims. I understand I am responsible for any charges not paid by my insurance.

Patient's signature (unless minor) _____ Date: _____/_____/_____

NEUROPSYCHOLOGY
ASSOCIATES, P.A.

1220 Main Avenue Suite 100
Fargo, ND 58103
Phone: 701-297-7588
Fax: 701-364-2256

New Patient (Child/Adolescent) Questionnaire

All information provided will be used for professional use only and will become part of the medical record.

Today's Date: _____

Child's Name: _____ Sex: M F

Date of Birth: _____ Age: _____ Grade: _____

Your Name: _____ Relationship to Child: _____

Are you the child's legal guardian? YES NO If not, who has guardianship? _____

PRESENTING CONCERN(S)

Who referred your child to us? _____

Why are we seeing your child for care? Please list the concerns you have regarding your child's cognitive, learning, or emotional/behavioral symptoms.

1. _____
   _____
2. _____
   _____
3. _____
   _____

What has been done to EVALUATE or TREAT these problems in the past? ***Please include copies of any prior evaluations.***

When	Place/Person	What was the result?

MEDICAL AND DEVELOPMENTAL HISTORY

Length of pregnancy _____ Child's Birth Weight_____

Mother's age when child was born_____ Child's Birth Length_____

Did any of the following occur for the **MOTHER** during pregnancy or delivery? If YES, please explain.

Problem	If YES, please explain
Serious illness or injury	
Hypertension (high blood pressure)	
Diabetes	
Autoimmune problems/conditions	
Concerns about mother's weight gain or baby's growth	
Took prescription medications	
Took illegal drugs	
Drank alcoholic beverages	
Smoked cigarettes	
Had a cesarean (C-section) delivery	
Other complications (low amniotic fluid, thyroid problems)	

Did any of the following occur with the **CHILD** during or shortly after delivery?

Problem	If YES, please explain
Injured during delivery	
Low Apgar scores	
Breathing problems	
Born with congenital (birth) defect	
Stayed in hospital longer than mom	
Other complications?	

Compared to other children, your child's early development was: Early On Time Late

If late, give details: _____

Please describe any other problems or concerns during child's early development: _____

Has your child EVER received physical therapy (PT), occupational therapy (OT), or speech-language therapy? Yes No

If yes, when/where: _____

_____

Has your child ever had psychological or neuropsychological testing for ADHD, learning problems, or other developmental concerns? Yes No ***If yes, please provide a copy of the evaluation report.***

Please list any chronic medical problems that are followed a doctor (asthma, seizures, heart problems, etc.). _____

_____

Who is your child's primary care provider? _____

Please mark if your child has EVER experienced any of the following medical or developmental problems/conditions? **If marked yes, please indicate when**.

_____ Loss of consciousness
_____ Head Injury
_____ Seizures/Convulsions
_____ Encephalitis or meningitis
_____ Headache (chronic or migraines)
_____ Chronic ear infections
_____ Hearing impairment
_____ Vision Impairment
_____ Speech/language problems
_____ Motor problems (including handwriting)
_____ Feeding problems
_____ Bowel/Bladder problems (chronic)
_____ Sleep problems (chronic)

Has your child had any serious illnesses, operations or hospitalizations? If yes, please explain. _____

_____

Has your child had any diagnostic tests (e.g., EEG, MRI, CT Scan)? If yes, please explain. _____

_____

What time does your child typically go to bed? _____ Wake up? _____

Does your child have any difficulty falling asleep at night? Yes / No If yes, when did this start? _____

Do you have any concerns about your child's eating? Yes /No If yes, please explain _____

Please list all **CURRENT** medications your child takes for **ANY** condition (medical or psychiatric).

Medication Name & Dose	Reason	Start Date	Is It Working?

MENTAL HEALTH TREATMENT HISTORY

Please list any problems your child has been diagnosed with.

Diagnosis	When?	Who Diagnosed?	Type of Treatment
Attention-Deficit/Hyperactivity Disorder (ADHD/ADD)			
Oppositional Defiant Disorder or Conduct Disorder			

Diagnosis	When?	Who Diagnosed?	Type of Treatment
Autism/Asperger's Disorder/ Pervasive Developmental Disorder			
Depression			
Anxiety			
Obsessive Compulsive Disorder			
Posttraumatic Stress Disorder			
Reactive Attachment Disorder			
Fine or Gross Motor Impairment			
Learning Disability (**Specify type**)			
Speech/Language Disorder			
Other:			

Has your child ever received the following mental health services?

	When	Where/Who	What was the result?
Medication for emotional/behavioral problems			
Therapy/Counseling			
Psychiatric hospitalization			
Psychological/Neuropsychological testing			

Please list all **PREVIOUS** medications (prescription or over-the-counter) your child has ever used for cognitive, emotional, or behavioral problems. _____

_____

SCHOOL HISTORY

Current grade _____ School: _____ District: _____

Has your child repeated a grade? Yes No If yes, which grade(s)? _____

What kind of grades does your child typically receive? _____

Are any subjects unusually challenging for your child? _____

_____

Does your child **CURRENTLY** receive special services at school (Title services, reading intervention, etc.)? Yes No

If yes, please describe: _____

Has your child **EVER** had any extra help like Title reading or Title math, or other extra support? Yes No

If yes, please describe: _____

Does your child have an IEP or 504 Plan? Yes No

If YES, please describe services and ***provide a copy***: _____

_____

Has your child undergone any testing (e.g., IQ, Academic Achievement) through the school district? Yes No

If yes, please describe the outcome and ***provide a copy*** of testing report: _____

_____

FAMILY AND SOCIAL HISTORY

Parents are (circle): Married Divorced Never Married do not have custody

If there is a legal custody or visitation agreement, please describe: _____

_____

Is the child adopted? Yes No If yes, does the child know? Yes No

Who lives in the child's home? Please include yourself and step- or half-siblings who may be there part-time.

Household #1

Name	Relationship to child	Age

Household #2

Name	Relationship to child	Age

Please describe the highest level of education (e.g., finished high school, some college) & current employment for the following people:

Parent	Current Age	Highest Grade Completed	Currently Employed As:
Biological Mother			
Biological Father			
Step / Adoptive / Guardian Mother			
Step / Adoptive / Guardian Father			

Please describe any major challenges, traumas, or stresses in your child's life (e.g. parent/family conflict, abuse/neglect, substance abuse, domestic violence, moves that were unusually difficult). _____

_____

_____

Has legal or social services been involved with your family? Never Currently In the past

If yes, please describe: _____

What techniques (e.g., time-out, removing privileges, rewards) are helpful in managing your child's behavior? _____

What techniques have you used that have been unsuccessful in managing your child's behavior? _____

List a few of your child's strengths and interests: _____

FAMILY MEDICAL AND PSYCHIATRIC HISTORY

Please complete with regard to the child's biological family history. If history is limited or largely unknown, please indicate.

Other	Maternal Aunt/Uncle	Paternal Aunt/Uncle	Maternal Grandparent	Paternal Grandparent	Sibling	Father	Mother	
								Attention Deficit/Hyperactivity Disorder (ADHD/ADD)
								Speech delays
								Reading problems or dyslexia
								Struggled in school or dropped out before graduating high school
								Autism/Asperger's disorder/Pervasive Developmental Disorder
								Mental retardation/intellectual disability
								Developmental delays
								Tics/Tourette syndrome
								Alcoholism/substance abuse (marijuana, meth, cocaine)
								Depression
								Anxiety disorder
								Suicide (attempts or completed)
								Bipolar disorder
								Schizophrenia or psychotic symptoms
								Assault behaviors

Thank you for taking the time to complete this form so that we can serve you better. To make the most of your consultation appointment, we recommend that you provide copies of the following:

- Any prior cognitive testing (i.e. IQ, achievement) conducted through the school or by an outside agency/provider such as a psychologist or neuropsychologist.
- Any prior occupational therapy assessment reports (school based or from a medical provider).
- Any prior speech-language assessment reports (school based or from a medical provider).
- Current IEP or 504 Plan.

If you have any questions as to what to provide, please do not hesitate to call us at 701-297-7588.

THIS FORM AND SUPPORTING RECORDS CAN BE RETURNED BY:

1) Faxing to 701-364-2256
2) Mailing to 1220 Main Avenue Suite 100, Fargo ND 58103

Due to privacy and security issues, we regret that we cannot accept patient information by email.

NEUROPSYCHOLOGY ASSOCIATES, PA
COMMUNICATION AUTHORIZATION

May we leave appointment information or return phone call messages with the person who answers the phone? Yes_____ No_____

May we leave appointment information or return phone call messages on your answering machine? Yes_____ No_____ Not applicable _____

CONTACTS:

With whom may we discuss patient's medical information or billing questions?

NOTE:

Please **ONLY** list family members or friends that might call on your behalf.
Example: mom, dad, brother, sister, spouse, significant other, etc

If you choose not to list anyone, please proceed to the bottom to sign and date.

1. _____ Phone_____
2. _____ Phone_____
3. _____ Phone_____
4. _____ Phone_____
5. _____ Phone_____

Print Patient's Name _____

Patient Signature (unless a minor) _____

Date: _____ /_____/_____

Please contact us if you want this information updated.

Notice of Privacy Practices Acknowledgement

Neuropsychology Associates, P.A.
1220 Main Ave, Suite 100
Fargo, ND 58103

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
Signature: _____
Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below

Date _____ Initials _____ Reason_____

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- ❖ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- ❖ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ❖ The right to inspect and copy your protected health information.
- ❖ The right to amend your protected health information.
- ❖ The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- ❖ The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Mary Jo Olmstead
Neuropsychology Associates, P.A.
1220 Main Ave, Suite 100
Fargo, ND 58103
701-297-7588

For more information about HIPAA
Or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NEUROPSYCHOLOGY
ASSOCIATES, P.A.

Payment Policy

DEDUCTIBLES/CO-INSURANCE/NON COVERED SERVICES:

-Deductibles/Co-insurances/Non-covered services are to be paid in **FULL** following insurance(s) reimbursement to our clinic. Please contact the clinic should you require other payment options.

If you have any questions, please feel free to contact Mary Jo at 701 297-7588.

Thank You.