Volusia Neuropsychology & Behavioral Health
REGISTRATION FORM

DATE OF APPOINTMENT:			
Please have your insurance card(s) and identification available to be photocopied			
PATIENT INFORMATION			
Patient's Name:			Marital Status (circle one): Single / Mar / Div / Sep / Wid / Par
Social Security No.:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street Address:			
P.O. Box:	City:	State:	ZIP Code:
Home Phone No.: ( )	Cell Phone No.: ( )	Work Phone No.: ( )	Other Phone No.: ( )
Occupation:	Employer:	Employer Phone No.: ( )	
Name of Primary Care Physician:		Phone No.:	
Date of Injury/Onset of Illness:		Motor Vehicle Accident?: ☐ Yes ☐ No	
Are you using an attorney for this incident? ☐ Yes ☐ No		If yes, please complete below:	
Attorney:		Phone No.: ( )	
Address:			
INSURANCE INFORMATION			
Person Responsible for bill:	Birth date: / /	Address (if different from patient):	Phone No.: ( )
Name of **PRIMARY** insurance:	ID/Policy No.:	Group No.: (if indicated on card)	
Name of **SECONDARY** insurance:	ID/Policy No.:	Group No.: (if indicated on card)	
IN CASE OF EMERGENCY			
Name of local friend/relative or spouse:	Relationship to Patient:	Home Phone No.: ( )	Cell or Work No.: ( )

I hereby acknowledge that I have received the Notice of Privacy Practices in accordance with HIPPA and that I agree to all the provisions therein. The above information is true to the best of my knowledge. Volusia Neuropsychology & Behavioral Health Inc may use my patient information as needed to submit billing(s) to my insurance company, attorney or other designated entity.

Patient/Guardian Signature _____ Date _____

Volusia Neuropsychology & Behavioral Health

Phone 386-423-0462 fax 386-423-0802

512 Canal St New Smyrna Beach Fl 32168

www.Volusianeuro.com | Volusianeuropsychology@MDofficemail.com

Patient Name _____

If VNBH needs to contact you for any reason may we leave a message?

_____Yes _____No

Would you like to receive a reminder call Before your appointment?

_____Yes _____No

If YES, please list the contact numbers you wish VNBH to use :

1ST preference: _____ Home_____Work_____Cell_____

2ND preference: _____ Home_____Work_____Cell_____

3RD preference: _____ Home_____Work_____Cell_____

_____ _____

Signature Date

Please note that if this form is not signed no reminder call will be made due to confidentiality concerns.

Volusia Neuropsychology & Behavioral Health
512 Canal St.
New Smyrna Beach, FL 32168
Phone #: 386-423-0442 Fax #: 386-423-0402

Cancellation Policy

Your appointment time is reserved exclusively for you. **Whether you receive a reminder call or not, your appointment time is your responsibility to keep or change in a timely manner.** Please help us serve you better by keeping scheduled appointments. Unless cancelled at least 24 hours in advance, you will be charged for the missed appointment/late cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

In order to assure that you and other patients receive timely services we ask that you try to arrive on time and/or no later than 15 minutes past the scheduled appointment time. Any late arrivals beyond 15 minutes will have to rescheduled and the cancellation fee will be assessed. Excessive cancellations or no shows will be subjected to consideration for discharge from the practice.

Thank you for your cooperation.

Read Carefully and Sign Below:
I understand that I will be billed a $80.00 fee in the event that I am a No Show for an appointment or for failure to cancel an appointment within 24 hours in advance of my scheduled appointment.

I also understand that late arrivals beyond 15 minutes of the original scheduled appointment time will be rescheduled and a $80.00 fee will be billed.

**By signing below, you are acknowledging that you have read this policy in its entirety and agree to the terms stated within this policy. **

Patient Signature Date

Patient's Printed Name

Volusia Neuropsychology & Behavioral Health

512 Canal St

New Smyrna Beach Fl 32168

Phone # 386-423-0442 **Fax # 386-423-0402**

CONSENT FOR PSYCHOLOGY/NEUROPSYCHOLOGICAL EVALUATION AND TREATMENT

I understand that the purpose of this evaluation is to provide information to my physician, health care provider, or other source who has requested the evaluation in order to assist in the diagnoses and/or treatment of any medical or psychological condition. the material from the interview and psychological/neurological testing will result in the generation of a report that will provide information related to diagnoses and/or treatment. The report generated by Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey, or Sharon Crane will be sent to my physician , health care provider, or other identified source and Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane may discuss results with them. If desired by me or my referring provider Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane will also discuss the results with me or any others which I so designate by signing a release of information allowing Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane to do so. If this evaluation and/or treatment is being covered or partially covered by my insurance, Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane may be required to provide the insurance company with the records as well.

I agree to cooperate to the best of my ability and understand that although I am expected to give honest and accurate answers I am free to refuse to answer and question i choose to or terminate the evaluating at any time I desire. i also understand that i may choose to terminate psychological treatment at any time.

the terms of the evaluation and/or treatment and any potential limits to confidentiality have been reviewed and understood and agreed to by me.

_____ _____

Patients Signature Date

_____

Patients Name

Volusia Neuropsychology & Behavioral Health
212 Canal St
New Smyrna Beach, FL 32168
Phone #: 386-423-0442 **Fax #: 386-423-0402**

Financial Policy/Assignment of Benefits

Patient's Name: _____ **Date of Birth:** _____

As a patient, it is your responsibility to familiarize yourself with the terms of your health care plan. Your insurance policy is a contract between you and your insurance company. We will make every attempt to collect payment from your insurance company. Payment for services rendered by any doctor's office or facility is based on "medical necessity". This is determined by your insurance company therefore: our office cannot guarantee that the services performed will be paid. We will make all effort to obtain appropriate authorization and pre-certification for services. However, you are ultimately financially responsible for all or part of services provided by our office not covered by your insurance company. **Your deductible and co-payments are amounts determined by your insurance coverage and you are required to pay these deductibles and co-payments at the time of service.**

I hereby instruct and direct the following insurance company(s)

To pay by check, which should be made payable and mailed to:

Volusia Neuropsychology & Behavioral Health, Inc.
512 Canal St
New Smyrna Beach, FL 32168-5200

Payable for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a timely manner, any balance of said professional service charges over and above any insurance payments.

A photocopy or facsimile of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Volusia Neuropsychology & Behavioral Health, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Patient Signature Date

_____
Policyholder Signature (if other than patient)

Volusia Neuropsychology & Behavioral Health
512 Canal St New Smyrna Beach Fl 32168
phone 386-423-0042 fax 386-423-0402

AUTHORIZATION TO RECEIVE AND/OR RELEASE INFORMATION

Patient Name_____ DOB:_____

I hereby authorize the name(s) or organizations written below to release verbally or in writing the use or disclosure of my Personal Health Information (PHI). I understand that these records are privileged information and will not be further discussed without specific written consent of the person to whom it pertains, or otherwise permitted by law.

I voluntarily authorize Lisa M. Merilson, Psy.D, Julie L. Parker, Psy.D, Christine Bailey Ph.D, Alexa Barnett Psy.D, Michael B. Meth, Psy. D and or Sharon L. Crane, LMHC of Volusia Neuropsychology & Behavioral Health to receive and/or release my PHI.

Name(s)/ Organization to receive and/or release my PHI: Phone # and/or Fax #

_____ _____

_____ _____

_____ _____

Disclosure may include the following verbal or written information (Check all that apply)

_____All treatment records _____ Lab/Diagnostic testing results _____History & Physical

_____Psychiatric treatment records _____Medication records _____School information

_____Other (please specify)_____

Expiration: I understand that this authorization shall remain in effect for 12 months from the date of signature, unless otherwise revoked by me in writing prior to that time.

Revoke Authorization: I understand that I have the right to revoke this authorization, in writing, at anytime by sending written notification to the office of VN&BH. I further understand that the revocation of the Authorization in not effective to the extent that action has been taken in the reliance on the authorization.

Redisclosure: I understand that the information that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information may no longer be protected by the HIPPAA Privacy Policy.

I may request a copy of this authorization for my records. I certify that all my questions were answered to my satisfaction and that I understand this Authorization form and all its concerns.

_____ _____

Signature of patient , Parent, Guardian or Representative Date

Client/Child's Name_____

CHILDREN & ADOLESCENT BIOPSYCHOSOCIAL HISTORY & ASSESSMENT

(For our clients under the age of 18-years-old)

*Please complete to the best of your ability the information below that asks questions about you or the child you are seeking services for.

SECTION 1: GENERAL INFORMATION:

Name of person who is completing this form: _____ Relationship to client/child: _____

Client/Child's Name:_____ Today's Date:_____

Address:_____
City:_____ State:_____ Zip Code:_____
How long has the child lived at this address:_____ Phone Number: _____

Client/Child's D.O.B.:_____ Gender: Male / Female Client/Child's SS#:_____

Client's Biological Mother's Name:_____
Client's Biological Father's Name: _____

Is there a custody agreement for the child you are seeking treatment for? If yes, please explain:
_____
Who has legal rights of the child you are seeking treatment for?
_____

If the child does not live with his/her biological mother or father, please complete the following information:
Primary Guardian(s) Names: _____
Primary Guardian(s) Address: _____
Primary Guardian(s) Telephone Number(s): _____

Who should be contacted if there is an emergency?

Emergency Contact's Name_____

Address_____

Phone Number_____

Relationship to Client_____

Who referred client/child for services?: □ Family member □ Friend □ Doctor □ Insurance Agency □ Phone Book □Internet □ Other _____

Presenting Problem/Recent Stressor(s) - What are the main reasons that you are seeking services for client/child at this time?
_____
_____
_____

Briefly describe how you hope that services through this agency may help you with your child:
_____
_____
_____

Client/Child's Name_____

Treatment Assignment Info (preferences are not guaranteed, but are helpful for our staff):

Do you have a preference as far as the therapist's gender for your child? □ Male □ Female □ Does not matter

Are there any other preferences regarding therapist/therapy for your child?

_____

What day/days or time of the day work best for you regarding scheduling future appointments? (Weekends/Evenings are not guaranteed)

_____

SECTION 2: CHIEF COMPLAINTS Place a check mark next to all symptoms below that help explain problems that your child is experiencing at the present time.

- □ Aggressive or violent behavior
- □ Anger issues
- □ Argues with adults
- □ Bladder or bowel control problems
- □ Complaints about school behavior
- □ Criminal behavior/Involved with juvenile probation
- □ Cruelty/harm to animals
- □ Depression, Sadness or feeling down
- □ Developmental Delays (delays in learning, growth, speech, social)
- □ Drug Use/Alcohol Use/Tobacco Use
- □ Easily Distracted
- □ Eating problems (Not eating enough/Overeating)
- □ Fatigue/feeling tired/lack of energy
- □ Fear of "going crazy"
- □ Fear of losing control
- □ Feeling detached from body
- □ Flashbacks
- □ Hopelessness
- □ Housebound (Does not want to leave the house)
- □ Hyperactivity (Full of energy all day long)
- □ Identity issues (Confusion about who your child wants to be)
- □ Inappropriate sexual behavior
- □ Impulsive behavior (Does not think before acting)
- □ Irritability (Often acts miserable and complains a lot)
- □ Loss of a loved one, Loss of a relationship
- □ Lying
- □ Mood swings
- □ Nervousness (Worrying)
- □ Nightmares
- □ Numerous physical complaints (Complains about feeling sick)
- □ Obsessive thoughts (Cannot stop thinking about something no matter how much they try not to.)
- □ Panic Attacks
- □ Paranoia (Extreme fear or distrust of others)
- □ Poor grades
- □ Poor hygiene
- □ Poor relationships with other children/peers
- □ Problems concentrating
- □ Problems remembering things
- □ Recent trauma (please specify): _____
- □ Refusing to go to school
- □ Relationship or family conflict
- □ Running away from home
- □ Seeing or hearing things that other people cannot see/hear
- □ Self-harm such as cutting/burning self
- □ Setting fires
- □ Other_____

Client/Child's Name_____

SECTION 3: PSYCHIATRIC/MENTAL HEALTH ASSESSMENT

1. Is your child currently receiving mental health treatment with this agency or through another agency? If yes, explain what other services they are currently receiving.

2. Has your child ever had counseling services before? If yes, please list where and when.

3. Has your child ever been hospitalized for mental health problems before? If yes, please list where and when.

4. Has your child ever been diagnosed with a mental health condition? If yes, please list the diagnosis/diagnoses and who made the diagnosis/diagnoses.

5. Has your child ever spent time in a residential treatment facility or another long term treatment facility? If yes, please list where and the dates that they were in treatment.

6. Has your child ever stated that they wanted to kill themselves? If yes, are these statements something that they have talked about recently? If yes to any of the above, please explain:

7. Has your child ever stated that they wanted to harm or threaten someone else? If yes, please explain:

8. Has your child ever cut, burned or injured themselves in a way that was not an accident? If yes, please explain and note if is this a current concern:

SECTION 4: BRIEF FAMILY HISTORY

1. Does your child have any family members who suffer from mental health problems? If yes, please explain:

2. Does your child have any family members who suffer from drug and/or alcohol problems? If yes, please explain:

Client/Child's Name_____

3. Does your child have any family members who have committed suicide? If yes, please explain:

4. Are there any concerns regarding family members (either living or deceased) that may be impacting your child at the present time? If yes, please explain.

SECTION 5: MEDICAL SCREENING: PERSONAL AND FAMILY MEDICAL HISTORY

1. Does your child have any current medical conditions? If yes, please list all current medical conditions.

2. Does your child complain about feeling sick and if so, what do they often complain that they feel sick from? Have they seen a doctor for any of these complaints?

3. Are there any family members close to your child that are suffering from any medical conditions that may be upsetting your child? If yes, please provide more information.

4. On average, how many hours of sleep does your child get per night?

5. To the best of your knowledge, what is your child's current weight and height? Do you or your doctor have any concerns about your child's weight?

6. Overall, do you think that your child has healthy eating habits? If no, please explain.

7. Does your child have a family doctor/primary care physician? If yes, please list doctor's name, agency they are affiliated with, and doctor's address and phone number if known.

8. Does your child take any medication(s)?If yes, please list their current medication name(s), dosage, how often they take the medication, who is prescribing the medication, and what they are taking the medication for.

Client/Child's Name_____

9. Does your child have any allergies that you know of? If yes, please list.

10. Has your child ever had surgery or been hospitalized for any medical problems? If yes, please explain.

SECTION 6: EDUCATION

1. Is your child in school? If yes, what grade and what is the name of their school?

2. Does your child have any behavior problems at school? If yes, please explain.

3. If your child attends school, do they have an IEP (Individualized Educational Plan)? If yes, please explain.

4. If your child attends school, do they receive any extra support in school for learning or behavior problems? If yes, please explain what services they receive.

5. Does your child have attendance problems with school? If yes, please explain.

6. Does your child have problems with their teacher(s) in school? If yes, please explain.

7. Please use the following space to list any other areas of concern that you may have concerning your child and his/her education.

SECTION 7: SOCIAL RELATIONSHIPS

1. How well does your child get along with other children (classmates, siblings)?

Client/Child's Name_____

2. How well does your child get along with adults?

3. Is your child able to make friends easily? Please explain.

4. Does your child bully others? If yes, please explain.

5. Do other children/peers bully your child? If yes, please explain.

SECTION 8: DEVELOPMENT

1. Was your child born healthy and without any complications? If no, please explain.

2. Did your child walk, talk, toilet train, etc. at the correct developmental times? If no, please explain.

3. Did/Does your child receive speech therapy, occupational therapy, physical therapy, etc? If yes, please explain.

4. Did your child have any exposure to drugs, alcohol or tobacco use by their mother during her pregnancy?

5. Was there any domestic violence between mother and any other parties when child's mother was pregnant with child? If yes, please explain.

SECTION 9: LIVING SITUATION

1. Who does your child live with currently? Please list ALL household members, their relationship to child, and how well they get along.

Client/Child's Name_____

2. Has your child had multiple changes in living situations throughout his/her life? If yes, please explain.

3. Is there anyone living in the child's household who is suffering from a mental illness? If yes, please explain.

4. Is there anyone living in the child's household who has a drug/alcohol problem? If yes, please explain.

5. If the child does not live with biological family members, does the child have any contact with any of their birth parents, biological brothers/sisters, grandparents, etc.? If yes, please explain.

SECTION 10: TRAUMA HISTORY

1. Has your child ever been physically, sexually, or emotionally abused? If yes, please explain.

2. Has your child ever witnessed any type of traumatic events in their life? For example, been involved in a natural disaster, witnessed domestic violence, watched someone they care about die, witnessed drug and alcohol use in the home, etc. If yes, please explain.

3. If the child has been abused, was this abuse reported to Childline, Children and Youth Agency, and/or the police? Please explain what actions were taken if any.

SECTION 11: ADDICTION HISTORY:

1. Has your child ever drunk alcohol? If yes, what did they drink and how much did they drink?

2. How frequently is your child drinking alcohol?

Client/Child's Name_____

3. How old was your child when they first started drinking alcohol?

4. Has your child ever used drugs? If yes, what specific drugs? How much did they use?

5. When was the last date your child used drugs? What did they use and how much did they use?

6. How frequently is your child using drugs?

7. How old was your child when they first started using drugs?

8. Has your child ever viewed pornographic materials? If yes, how frequently?

9. Does your child often continue to eat after they feel full? If yes, please explain.

10. Does your child ever feel guilty after eating? If yes, please explain.

11. Does your child ever deprive themselves of food? If yes, please explain.

12. Does your child spend excessive time with media devices such as phone/computer/gaming? If yes, please explain.

13. Is there any other behavior that you believe your child does in excess or are concerned about? If yes, please explain.

ADDICTION TREATMENT:

1. Have you ever been concerned at any time about any of the above behaviors listed in questions 1-13? If yes, please explain.

Client/Child's Name_____

2. Is anyone concerned about your child regarding the above behaviors listed in questions 1-13? If yes, please explain.

3. Have any of the above behaviors listed in questions 1-13 impacted your child's relationships with family and friends? If yes, please explain:

4. Have any of the above behaviors listed in questions 1-13 impacted your child's ability to perform their responsibilities at home, school and/or at work (if applicable)? If yes, please explain.

5. Has your child ever received treatment for any of the above behaviors listed in questions 1-13? If yes, where and when?

6. Would you like your child to receive help for any of the above behaviors listed in questions 1-13?

SECTION 12: CHILD'S STRENGTHS

1. What does your child enjoy doing for fun?

2. Who/What does your child have in their life that provides them with support and hope?

3. What do you think that your child can do that makes them stand out in a positive way?

4. Is your child involved in any activities in school or in the community, for example: work, sports, clubs, group activities or organizations? Please list these activities.

5. Does your child have anyone in the community who works with them to provide them and the family with extra support, for example: Caseworkers, Big Brother/Big Sister, etc.? If yes, please explain.

Client/Child's Name_____

SECTION 13: OTHER

Please use the following space to list anything concerning the client/child that may not have been asked that you would like to be addressed.

_____

_____

_____

_____

_____

_____

I verify all information is truthful to the best of my knowledge (please sign below):

_____

Parent/Guardian Signature Date

STAFF USE ONLY

I verify I reviewed the above information:

_____

Staff Signature Date

Printed Name of Clinician Reviewing this form_____

_____

Staff Signature Date

Printed Name of Clinician Reviewing this form_____

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			