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 386-423-0442 fax 386-423-0602

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

Volusia Neuropsychology & Behavioral Health, Inc.

Personal History—Adult

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ *City:* _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____

If you need more space for any of the questions please use the back of the sheet.

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression	___ Phobias/fears	___Social Isolation
___ Alcohol dependence	___ Fatigue	___ Recurring thoughts
___ Anger	___ Gambling	___ Sexual addiction
___ Appetite Changes	___Hallucinations	___ Sexual difficulties
___ Anxiety	___ Avoiding people	___ Changes in sleep
___ Hopelessness	___ Speech problems	___ Cyber addiction
___ Impulsivity	___ Suicidal thoughts	___ Depression
___ Irritability	___ Thoughts disorganized	___ Disorientation
___ Judgment errors	___ Distractibility	___ Loneliness
___ Memory impairment	___ Worrying	___ Drug dependence
___ Mood shifts	___ Panic Attacks	___Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

_____

_____

_____

_____

Marital Status (more than one answer may apply)

_____ Single _____ Married _____ # of times _____ Divorced _____ # of times

_____ Other (Separated, Cohabitation, etc) which? _____

Parental Information

_____ Parents legally married

_____ Parents have ever been separated

_____ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

_____

FAMILY INFORMATION

Relationship	Name	Age	Living? Yes	No
Mother				
Father				
Spouse				
Children				

SIGNIFICANT OTHERS (brothers, sisters, grandparents, step/half relatives)
Please specify relationship

Relationship	Name	Age	Living? Yes	No

Childhood Development

Are there special, unusual, or traumatic circumstances that affected your development? ___ Yes ___ No

If Yes, please describe: _____

Has there been history of child abuse? ____ Yes _____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect _____ Inadequate nutrition ____Other (please specify): _____

Comments re: childhood development: _____

_____

_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

___ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

___ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

___ Other (specify): _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes _____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges _____

_____

Are you presently on probation or parole? ___ Yes ___ No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___ Yes ___ No Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? ___ Yes ___ No

__ High school grad/GED

__ Vocational: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

__ College: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

__ Graduate: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ___ FT ___ PT ___ Temp ___ Laid-off ___ Disabled ___ Retired

__ Social Security ___ Student ___ Other (describe): _____

Military

Military experience? ___ Yes ___ No Combat experience? ___ Yes ___ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Medical/Physical Health History

___ AIDS
___ Alcoholism
___ Abdominal pain
___ Abortion
___ Allergies
___ Anemia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bronchitis
___ Bed wetting
___ Cancer
___ Chest pain
___ Chronic pain
___ Colds/Coughs
___ Constipation
___ Chicken Pox
___ Dental problems
___ Diabetes
___ Diarrhea
___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Frequent urination
___ Headaches
___ Hearing problems
___ Heart Palpitations
___ Hepatitis
___ High blood pressure
___ Kidney problems
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual pain
___ Miscarriages
___ Nausea
___ Neurological disorders
___ Nose bleeds
___ Pneumonia
___ Rheumatic Fever
___ Sexually transmitted diseases
___ Sleeping disorders
___ Sore Throat
___ Scarlet Fever
___ Sinusitis
___ Smallpox
___ Stroke
___ Sexual problems
___ Tonsillitis
___ Tuberculosis
___ Thyroid problems
___ Vision problems
___ Vomiting
___ Whooping cough
___ Other (describe)_____
_____

Current health concerns: _____

Please check if there have been any recent changes in the following:

___ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level
___ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Are you allergic to any medications or drugs?_____ Yes _____ No If Yes, describe: _____

_____

Are you under any medical care? _____ Yes _____No If Yes, who?_____

_____

Family history of medical problems: _____

_____

MEDICATION LIST

NAME OF MEDICATION	DOSAGE

If additional space is needed please continue on back of this form.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

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

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**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. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	