Volusia Neuropsychology & Behavioral Health

REGISTRATION FORM

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
Email:		Birth Date: / /	Sex: ☐ M ☐ F
Street Address:			
P.O. Box	City:	State:	ZIP Code:
Home Phone No.: ( )	Cell Phone No.: ( )	Work Phone No.: ( )	
Occupation:	Employer:	Employer Phone No.:	
Name of Primary Care Physician:		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 Name:	Phone No.: ( )
Address:	

INSURANCE INFORMATION

Person Responsible for bill:	Birth Date: / /	Phone No.:
Address (if different from patient):		

Primary Insurance:	ID/Policy No.:	Group No.:
Secondary Insurance:	ID/Policy No.:	Group No.:

EMERGENCY CONTACT

Name of Local Contact:	Relationship to Patient	Phone 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
221 N. Causeway, Suite B
New Smyrna Beach, FL 32169-5200
Phone #: 386-423-0442 Fax#: 386-423-0402

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 □ Other

2nd preference:_____ □ Home □ Work □ Cell □ Other

3rd preference:_____ □ Home □ Work □ Cell □ Other

_____ _____
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

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Authorization to Receive and/or Release Information

Patient Name: _____ DOB: _____
Please Print Name

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 disclosed without specific written consent of the person to whom it pertains, or as otherwise permitted by law.

I voluntarily authorized Lisa S. Merilson, Psy.D, Julie L. Parker, Psy.D, and/or Sharon L. Crane, LMHC of Volusia Neuropsychology & Behavior 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 (specify):				

Expiration:
I understand that this Authorization shall remain in effect for twelve (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 any time by sending written notification to the office of Volusia Neuropsychology & Behavioral Health. I further understand that the revocation of the Authorization is not effective to the extent that action has been taken in reliance on the Authorization.

Redisclosure:
I understand that the information used or disclosed pursuant to the Authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA 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 contents.

_____ _____
Signature of Patient, Parent, Guardian, or Representative Date

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ASSIGNMENT OF BENEFITS

Patient:_____ **Date of Birth:**_____

As a patient, it's 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)

Insurance Co.	Policy # and/or Claim #

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

Volusia Neuropsychology & Behavioral Health, Inc.
221 North Causeway, Suite B
New Smyrna Beach, FL 32169-5200

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 current 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.

_____
Date

_____ _____
Signature of Patient Signature of Policyholder, if other then Patient

VOLUSIA NEUROPSYCHOLOGY & BEHAVIORAL HEALTH
221 N. Causeway, Suite B
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Phone #: 386-423-0442 Fax #: 386-423-0402

Financial Policy

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.

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 be rescheduled and possibly the cancellation fee will be assessed. Also, excessive cancellations or no shows will be subject to consideration for discharge from care.

Thank you for your cooperation.

Read carefully and complete:
I understand that I will be billed a $60.00 fee in the event that I miss 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 time will have to be rescheduled.

Your signature below indicates that you have read this agreement and agree to its terms.

Patient Signature:_____

Patient Printed Name:_____

Volusia Neuropsychology & Behavioral Health
221 N. Causeway, Suite B
New Smyrna Beach, FL 32169
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Consent for Treatment and Limits of Confidentiality

Patient: _____ Date of Birth: _____

I hereby attest that I have voluntarily entered into treatment or give my consent for the minor or person under my legal guardianship mentioned above to receive treatment. Further, I consent to have treatment provided by Sharon L. Crane, LMHC. I understand that treatment may be discontinued at any time by either party. We encourage that this decision be discussed with the treating professional. This will help facilitate a more appropriate plan for discharge.

Generally, we may not disclose that a patient is receiving treatment at our office or discuss anything said during the treatment session. It will not be shared without written permission except under the following conditions:

1. The patient threatens suicide.
2. The patient threatens harm to another person(s), including murder, assault, or other physical harm.
3. The patient reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The patient reports abuse of the elderly.

State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies.

In addition, if the patient is involved in a legal action and claims mental health issues related to the legal action (i.e., plea of "Not Guilty by Reason of Insanity," or claiming emotional harm in a lawsuit), mental health records may be required to be released.

Communications between Sharon Crane, LMHC and the patient will otherwise be deemed confidential as stated under Florida state law.

Having read and understood the above, I agree to the Consent for Treatment and Limits of Confidentiality.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian (if applicable) 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	___ Dizziness	____Neurological disorders
___ Alcoholism	___ Drug abuse	____Nose bleeds
___ Abdominal pain	___ Epilepsy	____Pneumonia
___ Abortion	___ Ear infections	____Rheumatic Fever
___ Allergies	___ Eating problems	____Sexually transmitted diseases
___ Anemia	___ Fainting	____Sleeping disorders
___ Appendicitis	___ Fatigue	____Sore Throat
___ Arthritis	___ Frequent urination	____Scarlet Fever
___ Asthma	___ Headaches	____Sinusitis
___ Bronchitis	___ Hearing problems	____Smallpox
___ Bed wetting	___Heart Palpitations	____Stroke
___ Cancer	___ Hepatitis	____Sexual problems
___ Chest pain	___ High blood pressure	____Tonsillitis
___ Chronic pain	___ Kidney problems	____Tuberculosis
___ Colds/Coughs	___ Measles	____Thyroid problems
___ Constipation	___ Mononucleosis	____Vision problems
___ Chicken Pox	___ Mumps	____Vomiting
___ Dental problems	___ Menstrual pain	____Whooping cough
___ Diabetes	___ Miscarriages	____Other (describe)_____
___ Diarrhea	___Nausea	_____

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.

Counseling/Prior Treatment History

Information about **you (patient)** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___			
Suicidal thoughts/attempts	___	___			
Drug/alcohol treatment	___	___			
Hospitalizations	___	___			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___			

Do you feel suicidal at this time? ___ Yes ___ No

If Yes, explain: _____

_____

_____

Information about **family/significant others** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___			
Suicidal thoughts/attempts	___	___			
Drug/alcohol treatment	___	___			
Hospitalizations	___	___			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___			

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol					___	___	___	___
Barbiturates					___	___	___	___
Valium/Librium					___	___	___	___
Cocaine/Crack					___	___	___	___
Heroin/Opiates					___	___	___	___
Marijuana					___	___	___	___
PCP/LSD/Mescaline					___	___	___	___
Inhalants					___	___	___	___
Caffeine					___	___	___	___
Nicotine					___	___	___	___

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____