MISSION PSYCHOLOGY

PSYCHOLOGICAL ASSESSMENT & TREATMENT

7400 Blanco Rd., Ste 126 | San Antonio, TX 78216
T: 210-699-8700 F: 210-587-2454 missionpsychology.com

Patient Registration Information

Patient Name: _____ , _____ Sex: M [ ] F [ ]
Last *First* *Middle*

Date of Birth: _____ Home Phone: (___)_____ Cell/Work Phone: (___)_____

Address: _____ City: _____ State _____ Zip _____

Patient's SS#: _____ Email (only if we may contact you by email): _____

Please check if we may leave a message on your ☐ Home Phone? ☐ Cell Phone?

If Patient is a Minor below the age of 18:

Guardian's Name: _____ Cell/Work Phone: (__)_____

In Case of Emergency, Please Notify: Name: _____ Relationship _____Phone Number (___)_____

Chose Clinic Because/Referred to Clinic by (Please check one box)

☐ Dr. _____ ☐ Insurance Plan ☐ Hospital ☐ Family/Friend ☐ Convenient location ☐ Yellow Pages

☐ Other: _____

Payment (check one)

☐ I will pay for these services directly and do not wish to have you my bill insurance.

☐ Please bill my insurance using the following information

INSURANCE INFORMATION

Primary Insurance Name: _____ Name of Insured: _____

Primary Insured (Guarantor) SSN: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID or Policy Number: _____ Group Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: ( ) _____

Secondary Insurance Name: _____ Name of Insured: _____

Id or Policy Number: _____ Group Number: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

___ (initials) I authorize Russel Thompson, PhD & the above insurance provider(s) to release any information required to process my claims.

Cancellation Policy

___ (initial) Failure to cancel an appointment within 24 hours of the scheduled time is considered a "No-show" and is billed at the full rate. I understand that insurance usually does not pay for no-shows, and I will be responsible for the fee myself.

Authorization of treatment and payment

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Russel Thompson, PhD. I understand that I am financially responsible for any balance.

Signature: _____ Date: _____

Print Name: _____

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Consent and Agreement for Psychological Testing and Evaluation

I _____ agree to allow the psychologist to perform the following services: ❑ Psychological testing, assessment, or evaluation

- ❑ Consultation with my physician whose name is _____
- ❑ Consultation with school personnel
- ❑ Consultation with lawyers
- ❑ Deposition (that is, written testimony given to a court, but not made in open court)
- ❑ Testimony in court
- ❑ Other (describe):

This agreement concerns ❑ myself or ❑ _____

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, and any other activities to support these services. I understand that the fee for this (these) service(s) will be about $150 per hour. Although my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment for these services.

I understand that this evaluation is to be done for the purpose(s) of: _____

I also understand the psychologist agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a secure place to maintain their confidentiality. I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

_____ _____ _____

Signature of client /guardian | Printed name | Date

I, the psychologist, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____

Signature of psychologist | Printed name | Date

❑ Copy accepted by client ❑ Copy kept by psychologist

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NOTICE OF RECEIPT OF POLICY REGARDING PROTECTED HEALTH INFORMATION

Please sign below to indicate that you have been given the opportunity to review Russel Thompson, PhD's policies regarding protected health information. If you request it, we will provide you with a paper copy of the policy

_____
Printed Name

_____ _____
Signature **Date**

ADULT NEUROPSYCHOLOGY QUESTIONNAIRE
Russel Thompson, PhD

Name: _____ SSN: _____ DOB: __/__/__ Age: ____

What is the problem that brings you here?

What questions do you want the assessment to answer?

SOCIAL HISTORY:

Where were you born? _____ Where were you raised? _____

Who raised you? _____ How many brothers and sisters did you have? _____

Times Married ___ Status Now: NM/Single Marr Div Widowed/er For How Long?_____

Do you have any children? ☐ Yes ☐ No If so, list their ages: _____

List any Neurological disease(s) in your family:

List any Psychiatric disease(s) in your family:

EDUCATIONAL HISTORY:

Did you ever fail or repeat a grade?Yes No If Yes, Please explain: _____

List any "Special Education" classes (include year and school): _____

Did you have a Learning Disability? ____ If yes, what type or problem area?_____

Were you ever called Hyperactive? __ or Attention Deficit?: __ Where & When? _____

Did you take Ritalin to help you in school? _____ Other medicines (list)? _____

Check the following if they applied to you in school:

☐ Could not still	☐. Could not organize / finish work	☐. Always "on the go"
☐. "Fidgety" and restless	☐. Needed a lot of supervision	☐. Acted before thinking
☐. Could not stay seated	☐. Had trouble paying attention	☐ Got in a lot of trouble
☐. Destroying property	☐. Speaking out of turn	☐.Fighting
☐. Was a bully	☐. Used drugs or alcohol	☐. A "slow learner"

☐. Counseled a lot by principals, teachers, etc.

Were you on the Honor Roll or Dean's List? _____Never _____Rarely _____Usually _____Always

If you did <u>NOT</u> attend college: Highest grade completed _____ Year _____ Typical grades _____

If you left school before graduation, what was the reason? _____

If you <u>DID</u> attend college: Highest degree awarded _____ Year _____ School _____

Major subject_____ Minor subject _____ GPA _____

Future educational plans:

ADULT NEUROPSYCHOLOGY QUESTIONNAIRE
Russel Thompson, PhD

OCCUPATIONAL HISTORY:

Currently employed? ____ Occupation? _____ Start Date: _____

If not employed or retired, how long has it been since you worked? _____

Your major responsibilities on the job? _____

Job before this one? _____

What has been your main type of work through the years? _____

List any problems in your current or past work:_____

Military service? Yes No Branch: _____Service Dates: _____ Rank _____ MOS_____

What are your future occupational plans?

MEDICAL HISTORY

Were there any complications or problems with your mother's pregnancy and delivery?

Were you a full-term baby? _____ If not, how premature?_____ Your birth weight? _____

Please give your best guess of the age you walked _____ and talked _____

Have you ever had a significant head injury? Yes No

If yes, please describe injury, when, whether unconscious, and if so, how long?

Injury	When	Unconscious?	If so, how long?

Please check any of the following that you have ever had

☐ Coma	☐ Kidney disease	☐ Infections (type: _____
☐ Diabetes	☐ Liver disease	☐ Multiple Sclerosis
☐ Hypoglycemia	☐ Encephalitis	☐ Hypertension
☐ Seizures	☐ Arteriosclerosis	☐ Tumor/Cancer
☐ Meningitis	☐ Venereal disease	☐ Brain abscess (or aneurysm)
☐ Stroke	☐ Heart disease	☐ Thyroid problems
☐ Sun Stroke	☐ Delirium	☐ Amnesia/Memory
☐ Dementia	☐ Other (please list): _____	

Please check any of the following that you have ever experienced or been exposed to:

☐ Lead (in paint, etc)	☐ Toxic chemicals	☐ Electrical shock
☐ Carbon Monoxide	☐ Malnutrition	☐ Chemical accidents
☐ Industrial solvents	☐ Overcome by gas	☐ Lack of oxygen
☐ Partial drowning	☐ Other environmental trauma:	

ADULT NEUROPSYCHOLOGY QUESTIONNAIRE
Russel Thompson, PhD

Have you ever been seen by a Psychiatrist/Psychologist? Yes No.

If so, please explain when and why:

Have you ever attempted suicide? ☐ No ☐ Yes

Please check any of the following that you have experienced recently in the last few months/years:

☐ Impulsivity (act before thinking)	☐ Getting lost	☐ Periods of confusion
☐ Severe headaches	☐ Nausea or vomiting	☐ Temper outbursts
☐ Memory problems	☐ More easily frustrated	☐ Shaking or tremor
☐ Personality changes	☐ Change in smell or taste	☐ Walking differently
☐ Loss of interest	☐ Inability paying attention	☐ Shaking or tremor
☐ Hallucinations	☐ Problems with judgment	☐ Dizziness
☐ Difficulty doing things you used to do well	☐ Ringing in ears	☐ Blank spells
	☐ Visual changes	☐ Fainting
☐ Unusual weakness	☐ Hearing changes	☐ Loss of coordination
☐ Loss of bladder / bowel control	☐ Loss of ability to have sex	☐ Numbness in the body
☐ Burning/tinglingin the body	☐ Uncontrollable laughing or crying	

☐ Other: _____

Please explain items checked above:

Do you have arthritis or injuries in your shoulders, arms, or hands that would affect your feeling, strength, or speed in your limbs? Yes No Where?_____

Do you have a hearing loss? _____

Have you been told that you have a vision problem that requires glasses? _____

List ALL medicines you currently take, both prescribed and "over the counter":

Drug	Dosage	How long?	Side effects?

ADULT NEUROPSYCHOLOGY QUESTIONNAIRE
Russel Thompson, PhD

Current level of alcohol use:

Were you ever a heavy drinker in the past? Yes No

How much coffee do you drink? _____

Please list any other non-prescribed chemicals or drugs that you have abused now or in the past

Have you ever participated in any substance abuse treatment program? Yes No

If so, please describe:

Do you have an application for disability pending?___With VA?__With Social Security?
__Other____

What disability are you claiming?

_____

What language(s) do you use/speak most of the time?_____
What language(s) did you learn <u>first</u> as a child?_____
2nd Language?_____

If there is anything about your current functioning or about your past experiences that you think would be helpful to us, please write it here:

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CREDIT CARD AUTHORIZATION

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable, including, but not limited to, copayments, coinsurance, any amount applied to your deductible, no show appointment fees, and other billing charges. If you have any questions or concerns about this policy, please discuss with your psychologist before signing.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account. We will not charge your card until sending you at least two invoices by mail and doing our best to notify you by phone.

I authorize Russel Thompson, PhD and Associates **to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

□ **Visa** □ **Mastercard**

Credit Card Number _____

Expiration Date _____ / _____ / _____ **3digit Security Code**__ ___ ___

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request Russel Thompson, PhD and Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Russel Thompson, PhD and Associates. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Russel Thompson, PhD and Associates in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____