Integra Psychological Services, PLCC

611 TX HWY 78 SUITE 122
Wylie TX 75098
972-442-0605

1. "HOW MUCH WILL I OWE?" NEW INSURANCE PATIENT ACKNOWLEGDMENT FORM

Client Full Name:

"HOW MUCH WILL I OWE?" NEW PATIENT ACKNOWLEDGEMENT FORM

THIS FORM MUST BE SIGNED BY ALL NEW PATIENTS BEFORE BEING PROVIDED A DATE/TIME FOR THEIR EVALUATION

THE MAXIMUM AMOUNT YOU WILL OWE US (INTEGRA) FOR OUR TESTING/EVALUATION SERVICES AND A 1-PAGE EXAM SUMMARY REPORT = $1,500.00

YOUR INSURANCE CARRIER MAY PAY NONE, ALL, OR A PORTION OF THIS MAXMIMUM AMOUNT.

THE TOTAL AMOUNT YOU OWE TO US (INTEGRA) WILL ULTIMATELY BE: ~$1,500.00 - (the amount your insurance covers)

BY SIGNING THIS FORM, YOU ACKNOWLEDGE AND AGREE TO PAY THE MAXIMUM AMOUNT OF $1,500.00 LESS ANY PAYMENTS MADE FROM YOUR INSURANCE CARRIER.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT ALL OUTSTANDING BALANCES OWED TO US (INTEGRA) MUST BE PAID BY THE TEST RESULT FOLLOW-UP (last appointment).

At Integra, Dr. Armstrong and his clinical staff are licensed clinicians with highly advanced training and experience who provide a uniquely comprehensive approach for each patient undergoing psychological and neuropsychological testing/evaluation. This evaluation includes (but is not limited to): a review of all pertinent medical / academic records provided to us, a comprehensive diagnostic clinical interview, conduction of a neurobehavioral status exam, administering/scoring/interpreting of a wide range of psychological and neuropsychological tests and assessments, provision to you (and any third parties to whom you give us consent/permission) a written report (NOTE: this is a 1-page summary report with history, test results interpretation, diagnoses (if any), and treatment recommendations - if a more comprehensive report is required, the total charge for a comprehensive report is an additional $350.00), and a follow-up appointment with Dr. Armstrong and/or his clinical staff to review all the exam findings and recommendations in detail.

Please know that it is our ideal that we would be able to provide each incoming patient with the exact and total dollar amount they owe us for these comprehensive evaluation services. Unfortunately, insurance policies vary substantially from patient-to-patient, fluctuate in their coverage policies throughout the year, and it is ultimately impossible for us to determine how much your insurance will eventually pay us versus how much you will owe after we bill your insurance.

To simplify this process , we have identified a "WORST-CASE-SCENARIO" approximate amount that our patients MIGHT owe us AFTER their insurance has been billed. In our experience, many patients ultimately end up owing us less than this "worst-case-scenario" amount. Yet, to simplify the process for all of us and to provide each of our incoming patients with a concrete, transparent and up-front total price for our services, the following "worst-case-scenario" amount is what YOU (our patients) acknowledge and agree to pay to us (Integra) for the provision of the aforementioned evaluation services: $1,500.00

By signing this form, YOU agree to pay us $1,500.00 for the evaluation we provide and with the expectation that we will submit your claim to your insurance carrier and that this "worst-case-scenario" amount you owe us (Integra) MAY BE REDUCED as a result our contractual arrangement with your insurance, the amount your insurance decides to pay us, the deductible amount you have or haven't met, any co-insurance amount due to us per your insurance policy, and/or any co-payments due to us at the date/time of providing you services. Although we make every effort to ensure all claims are submitted and approved, UNFORTUNATELY WE CANNOT GAURANTEE YOU that the evaluation services we provide will be fully covered or partially covered by your insurance or that your insurance will ultimately comply with their contractual obligations to you as their customer or us as their contractor.

Again, by signing this form, you are agreeing to pay us a MAXIMUM "worst-case-scenario" amount of $1,500.00 for the neuropsychological/psychological evaluation services we provide to you unless your insurance reduces this amount after we submit your claim. YOU WILL NOT BE BILLED BY US UNTIL YOUR INSURANCE HAS PROVIDED THEIR PAYMENT TO US OR HAVE PROVIDED US A FINAL DETERMINATION FOR YOUR CLAIM. All patients should note that they are responsible for holding their insurance carrier accountable for any contractual arrangements made between them and their insurance carrier.

Thank you for partnering with us in providing as much transparency as possible for our services and for understanding the complexity of the insurance system as it pertains to us providing you with the highest quality of care in a manner that allows us to receive monies owed to us to keep our business/small practice running.

Sincerely,

Levi Armstrong, PsyD MSCP

Clinical Neuropsychologist & Owner

Integra Psychological Services, PLLC

Please check the below items to acknowledge receipt of this billing practice and the maximum potential cost of services rendered.

- [ ] I understand final cost of services may be up to $1,500.00 and that this amount will only be billed to me after my insurance carrier has made their final determination for my claim. This amount will be owed to Integra at the latest by the beginning of the examination results follow-up appointment. This rate may not be covered, may be only partially covered, or may be fully covered by my insurance insurance. Any remaining balance after insurance determination is my responsibility to pay.

Remaining Balance Payment Preferences: (check one):

___ Charge My Card Any Remaining Balance After Insurance Has Responded and/or Paid My Claim

___ Call Me at this Number _____ to Setup a Payment Plan for Any Remaining Balance After Insurance

Please sign and date this form to acknowledge and agree to the above information. Please email or fax this back to our offices upon signing this form.

Name of Person Financially Responsible for the Above (please print):_____

Signature_____Date:_____

Patient Name (first and last name)_____Patient DOB:_____

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INTEGRA
PSYCHOLOGICAL SERVICES

Levi Armstrong, PsyD, MSCP
Clinical Neuropsychologist

Supervisees of Dr. Armstrong:
Jess Allen, M.Ed., BCBA, LBA-TX
Rachael Taliancich, M.A., LPC-A
Maria Lippart, M.A.

PRACTICE POLICY ACKNOWLEDGEMENT FORM

Please sign below to indicate that you have carefully read and accept all the information provided in this packet.

We are so glad you have chosen our practice for your professional psychology and counseling needs. If you have any questions or have difficulty reading or understanding this information, we are more than happy to verbally review all this information with you. This document contains important information about our professional services and business policies. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and agree to our policies (via your signature below) before we provide you or your child psychological services. This document represents an agreement between you and Integra Psychological Services, PLLC. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred to us. After reading through the attached packet of information in its entirety, please sign below acknowledging that you have read the above information, insurance assignment and release, practice disclosure statements, policies on our fees and use of third party payors (e.g., insurance), informed consent for treatment (and if applicable, informed consent to receive clinical services from Dr. Armstrong's supervisees), limits of confidentiality, notice of privacy practices/rights to privacy, and have had the opportunity to discuss the contents with us. By signing below, you are also attesting that you consent to treatment by Dr. Levi Armstrong and/or his clinical staff at Integra Psychological Services, PLLC with the knowledge of the above conditions.

Patient Name:_____ Date of Birth:_____ Age:_____ Gender:_____

Physical Address (City, State, Zip):_____

Who Lives with the Patient?_____ Legal Guardian Name (if applicable):_____

Billing Address (where billing statements can be mailed):_____

Preferred Method of Communication (Circle One): Home Phone Cell Phone Work Phone Other:_____

Phone:_____ Email Address to Send Assessments/Results:_____

Do We Have Permission to Send Appointment Reminder Texts/Calls to the Above Phone Number? Yes No

Who Referred the Patient to Us?_____

PATIENT HEALTH INSURANCE INFORMATION

Primary Name on Policy:_____ Primary Policy Holder DOB:_____

Policy Holder's Address (if different from above):_____

Policy Holder's Phone: _____ Email of Policy Holder:_____

Insurance Carrier:_____ Insurance ID / Policy #_____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Primary Name on Policy:_____ Primary Policy Holder DOB:_____

Policy Holder's Address (if different from above):_____

Policy Holder's Phone: _____ Email of Policy Holder:_____

Insurance Carrier:_____ Insurance ID / Policy #_____

PATIENT or GUARDIAN SIGNATURE:_____ **DATE:**_____

Patient Name:_____Today's Date:_____

CREDIT CARD INFORMATION

By signing on page 1 of this document, you agree to have your credit card information stored by Integra Psychological Services, PLLC until your file has been closed. You also authorize Integra Psychological Services, PLLC to charge your credit card for any outstanding financial responsibilities such as copayments, coinsurance, no show/late cancellation fees and deductible payments. NOTE: Patients will be contacted prior to charging their card. Insurance does not cover any cancellation/no-show fee. If you are unable to keep your appointment for any reason, you must give 24 hours advance notice; otherwise, your deposit of $100.00 for any neuropsychological or psychological examination will be non-refundable and will not be applied toward your co-payment, deductible, or co-insurance. If the late cancellation is for therapy or counseling, you will be charged for the full amount of the session you have scheduled. We will also accept cash and checks for payments prior to services. **Please complete the credit card information section below as this information is required prior to any appointment can be scheduled.**

Name as it appears on credit card: _____

Card Type (Circle One): Visa MasterCard American Express Other: _____

Card Number: _____Expiration Date:_____3-Digit Code:_____

Billing Address Including Zip Code: _____

ASSIGNMENT / RELEASE / DISCLOSURE / CONSENT TO TREATMENT

My signature on page 1 of this packet certifies that I, the patient, or my dependent or guardian has insurance coverage with the above listed insurance carrier and assign directly to Integra Psychological Services, PLLC and/or Levi Armstrong, Psy.D., MSCP all insurance benefits, if any, for all agreed-upon services rendered at Integra Psychological Services, PLLC. The signature on the first page of this document attests to my understanding that I am financially responsible for all charges per contractual reimbursement schedules between Dr. Armstrong and your insurance carrier (even if the insurance carrier does not cover some or any of the services provided). I hereby authorize the administrative and/or clinical staff of Integra Psychological Services, PLLC and/or Levi Armstrong, Psy.D., MSCP to release all information necessary (including diagnoses, mental health records and substance abuse records) to my insurance carrier and/or other third-party payors in order to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

By signing page 1 of this document, I acknowledge that I (or the patient), or my referring party, have requested neuropsychological testing, psychological testing, counseling, neurofeedback, and/or consultation/psychological treatment from clinical neuropsychologist Dr. Levi Armstrong and/or the clinical staff at Integra Psychological Services, PLLC. As a licensed psychologist licensed to practice in the State of Texas, there are regulations that you can review regarding our practice and resources available to you under the licensing act. This disclosure statement is a part of those resources. As a patient you have the right to refuse any suggested treatment and the freedom to choose the psychologist and treatment best suited to your needs. You also have the right to request a change of therapy, referral to another psychologist/therapist, or to discontinue an evaluation and/or treatment at any time. This document also serves as a notice to the risks and benefits of participating in psychological services. Some of the potential risks involved in being provided psychological services include discovering psychological/neuropsychological aspects about yourself that you may find uncomfortable, as well as the potential that the evaluation in which you participate does not yield the results you would prefer, or your medical records being disclosed to third parties should your records be requested upon a court order signed by a judge. Every attempt will be made on our part to avoid and/or lessen the impact of these risks, although it is our ethical duty to remain as objective as possible in order to be the most helpful to you and/or your referring party. Participating in psychological services may also yield many benefits to you. Some of the benefits involved include being provided useful information about your psychological functioning with which you can, hopefully, begin to make changes and solve problems to improve your overall well-being. However, there are no guarantees that the services we provide will provide the aforementioned benefits, despite our best effort to do so. It will be our utmost goal to make this experience as pleasant as possible with the intention of helping you to the best of our ability. Should you have any complaints regarding our services provided, we would encourage you to speak with Dr. Armstrong regarding these matters. In the event that this does not resolve your concerns, you are also welcome to contact the Texas State Board of Examiners of Psychologists at the following contact information:

Texas State Board of Examiners of Psychologists
333 Guadalupe
Tower 2, Room 450
Austin, Texas 78701
1-800-821-3205

AUTHORIZATION FOR DISCLOSURE & RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____Date of Birth: _____ Last 4 of Social Sec. #_____

Note: Parents of minors who are divorced will need BOTH parents to sign this form, our practice policy acknowledgement form, HIPAA policies, and all pertinent consent forms prior to treatment OR the parent requesting the evaluation must provide a copy of the divorce decree indicating their right to consent to treatment for their child.

My signature above authorizes the clinical staff at Integra Psychological Services, PLLC to use professional judgment in deciding what specific information will be released and communicated and whether specific records should be disclosed or whether a summary of treatment should be disclosed instead of specific records. I understand that any treatment records concerning my medical / psychological / mental health treatment are confidential under Texas law (unless ordered by a court of law), and that a statutory privilege prohibits confidential treatment information from being disclosed without my consent. This authorization may be revoked at any time, except to the extent that information has already been released. If not revoked, it shall terminate one year from the date of authorization. I also authorize Levi Armstrong, Psy.D., MSCP and/or the clinical staff at Integra Psychological Services, PLLC to disclose and receive in both written and verbal communication the confidential medical and psychological records/information concerning the above listed patient to the identified person(s)/agencies to be named below:

1. Name of Person or Agency _____

Phone and Fax Number: _____

2. Name of Person or Agency _____

Phone and Fax Number: _____

3. Name of Person or Agency _____

Phone and Fax Number: _____

4. Name of Person or Agency _____

Phone and Fax Number: _____

5. Name of Person or Agency _____

Phone and Fax Number: _____

Patient or Guardian Signature: _____Today's Date (date of authorization): _____

Guardian #2 (if required) Printed Name:_____

Guardian #2 (if required) Signature:_____Date Signed_____

Release of information will be valid for one year from the date of authorization noted above unless otherwise terminated with written request from the patient or legal guardian.

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INTEGRA
PSYCHOLOGICAL SERVICES

Levi Armstrong, PsyD, MSCP
Clinical Neuropsychologist

Supervisees of Dr. Armstrong:
Jess Pearson-Allen, M.Ed., BCBA, LBA-TX
Maria Lippart, M.S.
Rachael Taliancich, LPC-A

Limits of Confidentiality / Notice of Privacy Practices & Privacy Rights / Practice Policies

Limits of Confidentiality: Information discussed in the neuropsychological or psychological evaluation will be incorporated into a neuropsychological (or psychological) evaluation report. If you are participating in therapy, a detailed progress note of each session will be electronically recorded and kept securely via an electronic medical record system and/or a HIPAA-compliant cloud server. Please note that per TSBEP Acts and Rules of the Board, any handwritten therapy notes do not constitute your medical record and will not be available or disclosed to anyone unless in compliance with a court order. It is our legal and ethical duty to protect your treatment records and your records with us will remain confidential and will not be shared without your written permission. State law mandates that mental health professionals may need to break confidentiality/share your treatment records and/or report the following (a-f) to the appropriate persons or agencies. In addition, if the patient is involved in a legal action, your health records may be required to be released without your consent per a court order. All communication between your healthcare provider and you will otherwise be deemed confidential except under the following conditions:

a) The patient threatens suicide or is believed to be in imminent harm to his or herself
b) The patient threatens harm to another person(s), including murder, assault, or other physical harm.
c) The patient reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
d) The patient reports abuse of the elderly or the disabled.
e) The patient makes a threat against a government agency.
f) A court order requesting your records and with notification to you that your records will be released.

Sessions, Scheduling, & Fee's: Appointments are scheduled directly by calling 972-442-0605. Psychological and neuropsychological evaluations typically require 1-10+ hours of direct or indirect time. Psychotherapy sessions and testing follow-up appointments typically last 50 minutes. Our hourly rate ranges between $175.00 - $250 per hour for these services, although a sliding scale is also available in some circumstances. However, we will discuss your obligations up front prior to your services. If you become involved in legal proceedings that require our participation, you will be expected to pay for all professional and administrative time, including preparation and transportation costs (port-to-port), even if we are called to testify by another party. Fees for these forensic services range between $300-$500 per hour.

Payment of Fees & Other Policies: You will be expected to pay for each appointment at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose your otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided and the amount due. If such legal action is necessary, its costs will be included in the claim. Timely payment and open discussion will prevent that mutually unpleasant experience. A $25 fee will be charged for any checks returned for insufficient funds. Sometimes it is necessary for us to cancel a session unexpectedly due to unforeseen circumstances such as court orders, subpoenas, personal, or professional emergencies. Whenever possible, we will make every effort to notify you in advance and reschedule your appointment.

Treatment of Minors / Policy for Patient Records Who Were Evaluated/Treated while Minors: It is the policy of this office that treatment of children under the age of 18 years will be provided only with the consent of their legal guardian or parent. By signing this consent form, you acknowledge that you are the guardian (as established by the state or an official divorce decree) of any minor presented for treatment. Copy of the custody agreement / divorce decree in the cases of divorce must be provided prior to treatment OR each legal guardian/custodial parent MUST sign a consent for treatment form prior to treatment or testing. It should also be noted that Dr. Armstrong and Dr. Tischer do not specialize in non-court ordered child custody evaluations. If you are currently anticipating your need for these services, he will happily provide you with the contact information of other clinicians who specialize in these matters. All psychological records pertaining to an adult patient (age 18+), who on the date of the evaluation was less than 18 years of age, and who was seen, evaluated, or treated by Integra Psychological Services, PLLC and/or Levi Armstrong, Psy.D.,MSCP, and/or Donya Tischer, M.A., Psy.D. are only accessible by parents, guardians, attorneys, etc. with the written consent of that now adult patient. That is, all previously signed release of records become null and void at the time of the patient's 18th birthday, and parents, guardians, attorneys, etc. will be not be permitted copies of any records without written consent by the patient unless a copy of legal guardianship or medical power of attorney is provided to us.

Responding to Requests of Information: The patient and/or legal guardians and/or any third party to whom your consent is given can request copies of your medical information. Please note that there may be a fee charged in association with producing your records. Please also note that all requests of records must be provided in writing, email, or fax and that it may take up to 14 days for us to produce the records.

NOTICE OF PRIVACY PRACTICES / HIPAA

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.

Understanding Your Health Information: Each time you visit a hospital, physician, or other health care provider, a record of your visit is made in order to manage the care you receive. Your healthcare provider listed on this document understands that the medical information that is recorded about you and your health is personal. The confidentiality of your health information is also protected under both state and federal law. This Notice of Privacy Practices describes how your healthcare provider may use and disclose your information and the rights that you have regarding your health information.

Your Health Information Rights: Although your health information is the physical property of the facility or practitioner that compiled it, the information belongs to you, and you have certain rights over that information. You have the right to: Request, in writing, a restriction on certain uses and disclosures of your health information. However, agreement with the request is not required by law, such as when it is determined that compliance with the restriction cannot be guaranteed; Inspect or obtain a copy of your health record as provided by law; Request, in writing, that your health record be amended as provided by law, if you feel the health information we have about you is incorrect or incomplete. You will be notified if the request cannot be granted; Request that we communicate with you about your health information in a specific way or to a specific location. Reasonable requests will be accommodated; Obtain accounting of disclosures of your health information as provided by law; Obtain a paper copy of the Notice of Privacy on request. You may exercise these rights by directing a request to the Privacy Office Contact list on this Notice.

Our Responsibilities: Your healthcare provider has certain responsibilities regarding your health information, including the requirement to: Maintain the privacy of your health information; Provide you with this Notice that describes your healthcare providers' legal duties and privacy practices regarding the information we obtain about you; Abide by the terms of the Notice currently in effect. Your healthcare provider reserves the right to change these information privacy policies and practices and to make the changes applicable to any health information that we maintain. If changes are made, the revised Notice of Privacy Practices will be made available at our office and will be supplied when requested.

Uses and Disclosures of Health Information without Authorization: When you obtain services from your healthcare provider, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. The following categories describe ways that your healthcare provider may use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment: For example: Disclosures of medical information about you may be made to physicians, nurses, technicians, medical residents, or others involved in taking care of you. This information may be disclosed to other physicians who are treating you or to other health care facilities involved in your care. Information may be shared with pharmacies, laboratories or radiology centers for the coordination of different treatment. **Your health information will be used for payment:** For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment. **Your health information will be used for health care operations:** For example: The information in your health care record may be used to evaluate and improve the quality of the care and services we provide. Students, volunteers, and trainees may have access to your health information for training and treatment purposes as they participate in continuing education, training, internships and residency programs. **Business Associates:** There are some services that we provide through contracts with third-party business associates. Examples include transcription agencies and copying services. To protect your health information, your healthcare provider requires these business associates to appropriately protect your information. **Continuity of Care:** In order to provide the continuity of your care, your information may be shared with other health care providers such as home health agencies. Information about you may be disclosed to community service agencies in order to obtain their services on your behalf.

Disclosures Requiring Verbal Agreement: Unless you give notice of an objection, and in accordance with your Authorization to Verbally Release Health Information, medical information may be released to a family member or other person who is involved in your medical care or who helps pay for your care. Information about you may be disclosed to notify a family member, legally authorized representative or other person responsible for your care about your location and general condition. This may include disclosures of information about you to an organization assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition. You will be given an opportunity to agree or object to these disclosures except as due to your incapacity or in emergency circumstances.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification
The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement: When a disclosure is required by federal, state, or local law, judicial or administrative proceedings or for law enforcement. Examples would be reporting gunshot wounds or child abuse, responding to court orders; For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medication, or devices; For health oversight activities, such as audits, inspections, or licensure investigations; To organ procurement organizations for the purpose of tissue donation or transplant; For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information; or the disclosure is that of a limited data set, where personal identifiers have been removed; To coroners and funeral directors for the purpose of identification, the determination of the cause of death or to perform their duties as authorized by law; To avoid serious threat to the health or safety of a person or the public; For specific government functions, such as protection of the President of the United States; For Worker's Compensation purposes; To military command authorities as required for members of the armed forces; To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

Other Allowable Uses and Disclosures without Authorization: Other uses or disclosures of your health information that may be made include: Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives; Notifying you of health-related benefits and services that may be of interest to you;

Required Uses and Disclosures: Under the law we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine compliance with federal privacy law.

Uses and Disclosures Requiring Authorization: Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

Privacy Complaints: You have a right to file a complaint if you believe your privacy rights have been violated. This complaint may be addressed to the Privacy Contact listed in this Notice, or to the Secretary of the U.S. Department of Health & Human Services. There will be no retaliation for registering a complaint.

Privacy Contact: Address any questions about this Notice or how to exercise your privacy rights to the applicable Privacy Officer Contact listed below.

Effective Date: 08/15/2019
Last Updated: 09/21/2019

Privacy Officer Contacts
Levi Armstrong, Psy.D., MSCP
P: 972-442-0605
F: 972-215-7150

PATIENT or GUARDIAN SIGNATURE:_____ **DATE:**_____

**** A COPY OF THESE POLICIES IS AVAILABLE UPON REQUEST****

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INTEGRA PSYCHOLOGICAL SERVICES

Levi Armstrong, PsyD, MSCP
Clinical Neuropsychologist

Supervisees of Dr. Armstrong:
Jess Allen, M.Ed., BCBA, LBA-TX
Rachael Taliancich, M.A., LPC-A
Maria Lippart, M.A.

NEW PATIENT BACKGROUND & HISTORY

Patient Name:_____DOB:_____Age:_____ Current Grade (or degree earned):_____

Biological Sex: _____ Gender:_____Ethnicity:_____Handedness: RIGHT LEFT BOTH

Who referred the patient to us (circle one / provide name)? Self Parent School Insurance Attorney:_____

Psychiatrist:_____Neurologist:_____Family Doctor:_____Counselor:_____

What specific questions would you like answered by this evaluation? _____

_____

_____

Developmental History

Was the Patient Born on time? Yes No Unknown Mother's Age at Conception:_____Father's Age at Conception:_____

Patient's Weight at Birth: _____Normal Pregnancy / Delivery? Yes No Unknown

Was the patient exposed to any of the following while in utero (circle all that apply): NONE Nicotine Alcohol Illegal drugs

Please List Any Complications with the Patient's Mother's Pregnancy or Delivery:_____

_____

Did the Patient Suffer any Major Childhood Illnesses, Injuries, or Hospitalizations? If so, please describe: _____

_____

Did the Patient Experience Any Delays with the Following Developmental Milestones (circle all that apply)? NONE

Gaining Weight/Feeding Sitting Up Crawling Walking Talking / Language / Speech Fine Motor Skills

Social Skills Reading/Writing/Math Self-Care & Personal Hygiene General Learning Skills

Briefly Describe the Patient's Early Childhood Personality Style, Social Skills, and/or Behaviors (ages 0-5):_____

_____

_____

During the Patient's Childhood, is/was there any History of the Following (circle all that apply): NONE

Walking on Toes Hand Flapping Motor Tics Vocal Tics Repetitive Motor Mannerisms Rocking Sensory Sensitivities

Defiant Behaviors Moodiness Poor Social Skills Fixated Interests Hyperactivity Attention Problems Academic Problems

Lazy Eye or Crossed-Eyed Motor Coordination Problems Other Developmental Challenges?_____

Academic History

Current Grade or Anticipated Grade (if on summer break):_____School District: _____

Highest Education (circle all that apply): GED H.S. Diploma Some College (# of hours completed):_____ Bachelor's Master's Doctorate

Has the Patient Ever Failed or Repeated a Grade? Yes No If Yes, which grade(s):_____

Academic Areas of Difficulty:_____

Academic Areas of Strength:_____

Grade Average in K-8th (approximate – Circle One): A's B's C's D's F's

Grade Average in High School (Circle One): A's B's C's D's F's N/A

Grade Average in College/Technical School (Circle One): A's B's C's D's F's N/A

Does the Patient Receive Any of the Following While in School?(circle all that apply)

ADD/ADHD Accommodations Reading, Writing or Math Accommodations Autism Accommodations Intellectual Disorder Accommodations

Speech Therapy Occupational Therapy Physical Therapy Special Education/IEP 504 Accommodations

Does the Patient Get into Trouble at School Very Often? Yes No If Yes, for what?_____

Briefly Describe the Patient's Social Skills in School:_____

_____

Please Provide Us with Any Academic Records / Results from Testing at School if Available

Medical & Mental Health History

Name(s) of Treating Physician(s) and Specialty:_____

CURRENTLY DIAGNOSED Medical and Mental Health Conditions:_____

_____

Surgical History (Purpose and Approximate Date): _____

_____

When was the patient's last well visit / physical? What were the results:_____

Current Height:_____Current Weight:_____Any Drug Allergies?_____

Does the Patient Have Any History of the Following? (Circle All That Apply)

Traumatic Brain Injury (TBI) Concussion Stroke Brain Cancer Seizures Heart Rhythm Problems Diabetes

Night Terrors Recurring Nightmares Exposure to Toxic Substances Alcohol/Drug Use Chronic Pain

Liver Disease Kidney Disease Genetic Disorders Neurological Illnesses Muscle Weakness Chemotherapy

Radiation Therapy Sleep Apnea Asthma Balance Problems/Dizziness Passing Out Other (add below)

Brief Details for Anything Circled Above:_____

Please List ALL Current Medications, OTC Medications, and Supplements

Medication Name DOSAGE When Taken? Who Prescribed?

_____

_____

_____

_____

_____

_____

Adaptive Functioning & Independence

Does the patient have any problems completing these tasks at an age-appropriate level of independence?

Getting Dressed Personal Hygiene Eating Communicating Making Friends Academic Skills Driving Managing Money

Completing Chores Managing Homework Taking Medication Dealing with Transitions Coping with Stressful Situations

Mental Health Treatment History

Has the Patient Ever Participated in Counseling? Yes No If Yes, when and where:_____

Any History of Inpatient Mental Health Hospitalizations or Residential Hospitalizations? Yes No

If Yes, when/where/why?_____

Has the Patient Ever Attempted Suicide or Engaged in Self-Harming Behaviors? Yes No

If Yes, please describe (when, how, what happened?):_____

Has the Patient Ever Engaged in or Been Suspected of (circle one): Anorexia Bulimia None Other:_____

Does the Patient Have Any History of Using Alcohol, Drugs, or Tobacco? Yes No Unknown

If Yes, which ones?:_____

Has the Patient Ever Been the Victim of Abuse or Witnessed Domestic Violence: Yes No

Does the Patient Have Recurring Nightmares Related to Being the Victim of Abuse or Witnessing Domestic Violence: Yes No

Does the Patient Experience or Complain of Any of the Following (Circle all that apply): NONE

Hearing Voices Visual Hallucinations Paranoia Delusional Thinking Episodes of Increased Energy/Agitation

Decreased Need for Sleep Depressed Mood Panic Attacks Compulsive Behaviors Rapid Thoughts

Family Medical/Mental Health History

Biological Mother's Medical Conditions and Mental Health Diagnoses:_____

_____

Biological Father's Medical Conditions and Mental Health Diagnoses:_____

_____

Biological Sibling's Medical and Mental Health Diagnoses:_____

_____

Any Family History of the Following (Circle All that Apply):

ADD/ADHD Autism/Asperger's Intellectual Disability Anxiety Depression Bipolar OCD Schizophrenia

Learning Disabilities Speech Problems Seizure Disorder Brain Cancer Stroke Dementia Multiple Sclerosis

Legal History

On behalf of your child, do you plan to apply for Social Security Disability benefits? Yes No

Has the Patient Ever Been Arrested? Yes No If Yes, When and For What?_____

Employment History (if applicable)

Is the Patient Currently Employed? Yes No If Yes: Part-Time Full-Time # of hours per week spent working:_____

Current Job Title / Place of Employment:_____

Average Annual Salary:_____Any Significant Conflicts or Stressors at Work?_____

_____

Military History (if applicable – please specific if involved in active combat, rank, and job title/duties):_____

_____

Patient Name:_____ Date:_____

NEW PATIENT SYMPTOM SURVEY

Please Write "None" if No Problems are Present
or Provide Details of Any Difficulties in the Following Areas

Attention/Concentration:_____

Processing Speed:_____

Short-Term Memory:_____

Long-Term/Remote Memory:_____

Speech or Language:_____

Academic Skills:_____

Visual-Spatial/Navigating/Hands-On Problem Solving:_____

EF - Planning/Prioritizing/Organizing:_____

EF - Taking or Sustaining Initiative:_____

EF - Emotional Regulation or Self-Awareness:_____

Mood / Sadness / Depression / Irritability:_____

Suicidal Thoughts:_____

Anxiety/Worry:_____

Obsessions/Compulsions:_____

Social Support:_____

Hallucinations/Paranoia/Delusions:_____

Physical Pain / Headaches:_____

Energy Level Most Days:_____

Sleep:_____

Appetite:_____

Fine Motor Coordination or Tremor:_____

Balance / Passing Out / Dizziness:_____

Numbness / Tingling / Muscle Weakness:_____

Vision/Hearing/Smelling:_____

Heart Rhythm or Breathing Problems:_____