



# Neuropsychology & Counseling Associates, LLC

Theodore J. Batlas, Psy.D., Licensed Psychologist #02633

Jay B. Gordon, Ph. D., Licensed Psychologist #37590

## Consent for Purposes of Treatment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Neuropsychology & Counseling Associates, LLC for the purposes of diagnosing or providing treatment to me and in obtaining payment for my health care bills. I understand that diagnosis or treatment of me by Neuropsychology & Counseling Associates, LLC may be conditioned upon my consent and evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Neuropsychology & Counseling Associates, LLC is not required to agree to a restriction that I request. However, if Neuropsychology & Counseling Associates, LLC agrees to a restriction that I request, the restriction is binding on Neuropsychology & Counseling Associates, LLC. I have the right to revoke this consent, in writing at any time, except to the extent that Neuropsychology & Counseling Associates, LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Neuropsychology & Counseling Associates, LLC, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Neuropsychology & Counseling Associates, LLC Notice of Privacy Practices prior to signing this document and this has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the professional health care operations of Neuropsychology & Counseling Associates, LLC. This Notice also describes my rights and Neuropsychology & Counseling Associates, LLC duties with respect to my protected health information.

Neuropsychology & Counseling Associates, LLC reserves the right to change the Privacy Practices that are described. I may obtain a revised copy by calling the office, and I have the right to revoke this consent at anytime.

Our office will make every attempt to collect payment for your insurance company, please remember that payment of your bill is ultimately your responsibility. Your deductible and co-payment amounts are determined by the insurance coverage you and your employer selected. You are required to pay these deductibles and co-payments at the time of service. If you are in dispute of these amounts, it is your responsibility to address the problem with your insurance company. A "covered service" does not necessarily mean that it will be a paid service. As a result, you may be financially responsible for all or part of the services provided by our office.

I have read the information listed above and understand that I am financially responsible for all services not paid by my insurance company.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date:

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## PATIENT REGISTRATION (Please complete all information)

Patient Name:

(First) \_\_\_\_\_ (Last) \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work or Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female

Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Full Name of Referring or Primary Care Physician: \_\_\_\_\_

Dr.'s Phone Number \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance Information:

Insurance Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

ID#: \_\_\_\_\_ Group# \_\_\_\_\_

Insured Full Name: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured Relationship to Patient: \_\_\_\_\_

Secondary Insurance: (Medicare patients only)

Insurance Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

ID#: \_\_\_\_\_

### RELEASE FOR PROFESSIONAL INFORMATION

I \_\_\_\_\_ hereby authorize Neuropsychology & Counseling Associates to  
\_\_\_\_\_ obtain/or \_\_\_\_\_ release protected information pertaining to my treatment. This information should only  
be released to the following:

Physicians: \_\_\_\_\_

Attorney: \_\_\_\_\_

Other: \_\_\_\_\_

This authorization can be revoked in writing at any time by the person signing below and will expire when  
treatment ends. ( If patient is a minor, both parents or guardian are required to sign this release. (If minor is  
14 years or older their signature is required)

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

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TODAY'S DATE: \_\_\_\_\_ NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### CLIENT HISTORY

Please fill this form out to the best of your knowledge. Try to be as exact and complete as possible in your answers.

#### MEDICAL/HEALTH INFORMATION

How were you referred to this office? (name of referring physician or organization)

Reason for referral? \_\_\_\_\_

Has client ever had:

Head injury?.....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

Stroke? .....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

Other brain injury? .....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

Concussion?.....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

Loss of consciousness or coma? ...No \_\_\_\_\_ Yes \_\_\_\_\_ If so, how long? \_\_\_\_\_

Was client hospitalized?.....No \_\_\_\_\_ Yes \_\_\_\_\_ If so, how long? \_\_\_\_\_

Name and Address of Hospital? \_\_\_\_\_

Details? \_\_\_\_\_

#### PAST MEDICAL AND PSYCHOLOGICAL TESTS

Has client ever had any of the following tests?

Neurologic exam?.....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

MRI.....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

CAT (CT) Scan? .....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

EEG?.....No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

Psychological Tests/Evaluation...No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

Details: \_\_\_\_\_

#### PAST MEDICAL AND PSYCHOLOGICAL HISTORY

Has client ever (prior to the current incident) had:

Diabetes?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Heart disease?..... Yes \_\_\_\_\_ No \_\_\_\_\_

High blood pressure?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Hypoglycemia?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Seizures? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Thyroid Problems?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Asthma?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Allergies?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Learning disabilities? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Drug or alcohol abuse? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Psychological/Psychiatric problems? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Neurologic disease?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Surgery? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Toxic exposures?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Other medical disease?..... Yes \_\_\_\_\_ No \_\_\_\_\_

If so, when? \_\_\_\_\_

Details: \_\_\_\_\_

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CURRENT HEALTH

Please describe, in your own words, your current health:

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Does client suffer from any of the following symptoms?

Headaches? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Backaches? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Sexual problems? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Significant weight change?..... Yes \_\_\_\_\_ No \_\_\_\_\_ Gain or loss?

Numbness/weakness on either side of body.. Yes \_\_\_\_\_ No \_\_\_\_\_

Pain?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Location \_\_\_\_\_

---

Poor vision? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Sensitivity to light?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Sensitivity to noise?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Hearing impairment?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Tinnitus (ringing in ears)?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Decrease or increase in appetite?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Change in taste?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Change in smell?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Loss of balance?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Poor coordination/Dizziness?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Nausea?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Sleep difficulty? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Nightmares?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Changes in judgement?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Poor concentration?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Forgetfulness?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Difficulty making decisions?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Slowed thinking?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Difficulty comprehending what others say?. Yes \_\_\_\_\_ No \_\_\_\_\_

Difficulty managing daily activities?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Language/Speech difficulty?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain

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Changes in personality?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Feelings of depression?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Feelings of irritability?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Frequent racing thoughts?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Anxiety/fear/panic?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Feelings of unreality?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Nervousness/shakiness?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Decreased energy?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Teeth grinding/clenching?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Cold hands/feet?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Sweating hands/feet?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Heart pounding/racing?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Thoughts of hurting yourself?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Thoughts of hurting others?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Marital discord?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Problems with family or friends?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Trouble participating in social settings?. Yes \_\_\_\_\_ No \_\_\_\_\_

Trouble participating in sports?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Problems in work performance?..... Yes \_\_\_\_\_ No \_\_\_\_\_

Fear of driving or riding in automobile?.. Yes \_\_\_\_\_ No \_\_\_\_\_

Flashbacks?..... Yes \_\_\_\_\_ No \_\_\_\_\_

MEDICATIONS

Name of medication

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How well do you relax when you have problems and need to relax?  
(rate from 0-10, 10 being best) \_\_\_\_\_

Explain how: \_\_\_\_\_

ALCOHOL USAGE

Please circle the one that applies to client:

Never or rarely drinks alcohol.      Drinks socially only.  
Drinks nearly every day.              Has been treated for alcoholism

FAMILY HISTORY

Mother:      Age \_\_\_\_\_ Deceased? No \_\_\_\_\_ Yes \_\_\_\_\_ If so when? \_\_\_\_\_  
Cause: \_\_\_\_\_

Father:      Age \_\_\_\_\_ Deceased? No \_\_\_\_\_ Yes \_\_\_\_\_ If so when? \_\_\_\_\_  
Cause: \_\_\_\_\_

Any brothers and/or sisters? ..... No \_\_\_\_\_ Yes \_\_\_\_\_  
Names and ages: \_\_\_\_\_  
\_\_\_\_\_

Any children? ..... No \_\_\_\_\_ Yes \_\_\_\_\_  
Names and ages: \_\_\_\_\_  
\_\_\_\_\_

Do any family members have any of the following: (If so, please specify who)

Psychiatric or psychological problems? \_\_\_\_\_  
Learning disabilities? \_\_\_\_\_  
Alcoholism/Substance Abuse? \_\_\_\_\_  
Alzheimer's Disease or Dementia? \_\_\_\_\_  
Other Neurological problems? \_\_\_\_\_

MARITAL HISTORY

Is client currently?:

Single \_\_\_\_\_ Widowed \_\_\_\_\_ Engaged \_\_\_\_\_ Married \_\_\_\_\_ if so, how long? \_\_\_\_\_

LIVING ARRANGEMENTS

List everyone living in the home. (Name, age & relationship)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SOCIAL HISTORY

Education: Highest grade or degree completed \_\_\_\_\_  
If you attended college, which one? \_\_\_\_\_  
Learning disabilities? \_\_\_\_\_

Work: Is client working now? \_\_\_\_\_ If not, when did you stop? \_\_\_\_\_  
Present occupation? \_\_\_\_\_  
How long at present work? \_\_\_\_\_

OTHER COMMENTS OR RELEVANT INFORMATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## NEUROPSYCHOLOGICAL EVALUATION WAIVER

If you have been recommended to receive a complete Neuropsychological Evaluation, Procedure code 96119. Please be advised that although this is a covered service by some insurance plans, it is provided in our office by a technician. The technicians in our office do not participate with any insurance plans.

This service will be provided to you at a reduced rate. You are responsible for payment of this procedure prior to your appointment.

There is no guarantee that your insurance plan will reimburse you for these services. Our office is not required to submit services to insurance for non-participating providers. Submission to insurance will be solely your responsibility.

I acknowledge that I have read and fully understand the information provided above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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We reserve the right to charge a fee of \$50.00 for missed appointments, late arrivals, or cancelled services scheduled for you if you.....

1. **Fail to call 24 hours in advance to cancel or reschedule.**
2. **Fail to attend the appointment without giving 24 hours notice.**
3. **Arrive too late for the doctor to see you at your scheduled time.**

Please understand that this is a courtesy to your fellow patients and is being done to allow us the opportunity to know when we will have time available to see a new patient or a patient who need to be seen emergently. Please note that you will be charged the \$50.00 fee whether we have called you to confirm your appointment or not. We are unable to confirm all appointments. Attempts we make to do so are done only as a courtesy. *It is your responsibility to know when you have an appointment and to keep it.*

My signature confirms that I have been made aware of this policy and agree to pay the fee of \$50.00 as outlined above:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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