



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:

1683 Rt. 88 West • Brick, NJ • 08724 • Phone: 732-840-5266 • Fax: 732-840-7840

495 Iron Bridge Rd., Ste. 8 • Freehold, NJ 07728 • Phone: 732-294-5588

1301 Rt. 72 West, Suite 250 (SOCH Health Village) • Manahawkin, NJ 08050 • Phone: 609-597-5521

www.neuronj.com

www.add-solutions-nj.com



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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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