

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:

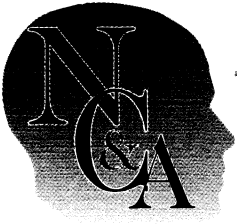
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495 Iron Bridge Rd., Ste. 8 • Freehold, NJ 07728 • Phone: 732-294-5588

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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: _____

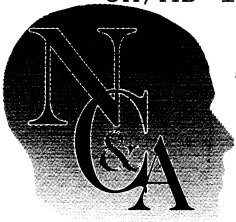
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TODAY'S DATE: _____

NAME: _____
Last Name, First Name, M. Intl.

Age: _____ Date of Birth ____/____/____

CLIENT HISTORY

Please complete to the best of your knowledge. Try being as exact 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 _____
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?

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:

Heart disease?..... Yes _____ No _____
High blood pressure?..... Yes _____ No _____
Diabetes? Yes _____ No _____
Seizures? Yes _____ No _____
Thyroid Problems?..... Yes _____ No _____
Asthma?..... Yes _____ No _____
Learning disabilities? Yes _____ No _____
Attention Deficit Disorder (ADD or ADHD) .. Yes _____ No _____
Drug or alcohol abuse? Yes _____ No _____
Psychological/Psychiatric problems? Yes _____ No _____
Neurologic disease?..... Yes _____ No _____

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Surgery? Yes _____ No _____
 Toxic exposures?..... Yes _____ No _____
 Other medical disease?..... Yes _____ No _____

If so, when? _____
 Details: _____

CURRENT HEALTH

Does client suffer from any of the following symptoms?

Headaches? Yes _____ No _____
 Backaches? Yes _____ No _____
 Sexual problems? Yes _____ No _____
 Menstrual difficulties? Yes _____ No _____
 Stomach 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 _____
 Nausea?..... Yes _____ No _____
 Dizziness?..... 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 _____
 Easily Distracted?..... Yes _____ No _____
 Slowed thinking?..... Yes _____ No _____
 Difficulty comprehending what others say? Yes _____ No _____
 Academic difficulties in school?..... Yes _____ No _____
 Difficulty managing daily activities?..... Yes _____ No _____
 Language/Speech difficulty?..... Yes _____ No _____

Please explain

Changes in personality?..... Yes _____ No _____
 Feelings of depression?..... Yes _____ No _____
 Feelings of irritability?..... Yes _____ No _____
 Poor frustration tolerance?..... Yes _____ No _____
 Frequent negative thoughts?..... Yes _____ No _____
 Frequent racing thoughts?..... Yes _____ No _____
 Periods of hyperactivity?..... 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 _____
 Behavioral difficulties in school?..... Yes _____ No _____
 Problems with family or friends?..... Yes _____ No _____
 Trouble participating in social settings? Yes _____ No _____

Trouble participating in sports?..... Yes _____ No _____
Fear of driving or riding in automobile?.. Yes _____ No _____

MEDICATIONS

Name(s) of Medications _____

Dosage _____

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)

- Diabetes? _____
- Hypertension? _____
- Thyroid Disease? _____
- Epilepsy or seizure disorder? _____
- Parkinson's Disease? _____
- Multiple Sclerosis? _____
- Mental retardation? _____
- Psychiatric or psychological problems? _____
- Learning disabilities? _____
- Attention Deficit Disorder? _____
- Alcoholism/Substance Abuse? _____
- Alzheimer's Disease or Dementia? _____
- Other Neurological problems? _____

LIVING ARRANGEMENTS

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

ACADEMIC/VOCATIONAL HISTORY

Education: Name of school? _____

Please list subjects client has received the best grades in
(Please also list grade received)

Please list subjects client has received the poorest grades in
(Please also list grade received)

Work: Is client working now? Yes _____ No _____

Is client currently driving? Yes _____ No _____



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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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