PSYCHOLOGY CENTER of IDAHO FALLS

3670 S. 25th E. Suite 2; Idaho Falls, ID 83404; Phone: 208-522-3404

Registration Form - Testing

Name_____ Male____ Female____

Mailing Address _____
_____
_____

Phone: Home_____ Work/Cell_____

Age: _____ Date of Birth: _____ Birthplace: _____

Referral Source: _____ Social Security #:_____

Current Concerns: _____
_____
_____
_____
_____
_____
_____
_____

Current Medications: _____
_____
_____
_____
_____

Employer/School Information:
Occupation: _____
Employer: _____

Highest Grade Completed: _____ Current Grade (if applicable): _____
Current School (if a student):_____

Primary Care Physician: _____

Insurance:
Insurance Company: _____ Policy #:_____

Policy Holder's Name: _____ Policy Holder's Date of Birth:_____

Copy of the Card taken? Yes No

PSYCHOLOGY CENTER of IDAHO FALLS

TESTING CONSENT FORM

This form will provide information about services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your psychologist (Dr. Aaron Harris or Dr. Carol Anderson.) Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

TESTING:
Through the use of a variety of standard psychological and/or neuropsychological tests, we will attempt to answer the questions that have brought you here for this assessment. These questions generally concern learning disabilities, behavioral problems, developmental delays, academic functioning, mood problems, personality functioning, cognitive decline, problems with attention/concentration, or symptoms following a brain injury. Throughout the assessment you have the right to inquire about the nature or purpose of all procedures. You have the right to withdraw from the testing session at any time. You also have the right to know the test results, interpretations, and recommendations.

The assessment process generally involves an informational intake interview followed by the administration of one or more educational and/or psychological or neuropsychological tests. Although it is sometimes possible to complete neuropsychological testing process in one sitting, it is most common for people to be tested over two half-day sessions. Once testing is completed and the data have been analyzed, a report will be issued and you will have the opportunity to ask questions and/or discuss the results with your psychologist.

CONFIDENTIALITY:
The information obtained in this evaluation is confidential and will not be released to any person or organization without your written permission. The only exceptions to this policy are rare situations in which we are required by law to release information without your permission. These are 1) if there is evidence of physical and/or sexual abuse of children, or abuse to the elderly; 2) if we judge that you are in danger of harming yourself or another individual; and 3) if your records are subpoenaed by the court. In the rare event of any of these situations, we would attempt to discuss our intentions with you before an action is taken, and would limit disclosure of confidential information to the minimum necessary to ensure safety.

FEE AND PAYMENT POLICY:
The standard fee for evaluation is $175/hour for testing. The Clinical Interview is billed at $250. Submission to private insurance companies for reimbursement may be done, upon request. All co-pays are due at the time of service. Any portion of the bill that goes unpaid by the insurance carrier will be billed to the patient. It is the responsibility of the patient/guardian to inquire about and obtain pre-authorization when required by his/her insurance carrier. The estimated cost of this evaluation is $_____. Your portion is estimated to be $_____.

AGREEMENT:
I have read the above material, and I fully understand my rights and obligations as a client**. I understand that the interpretation of assessment findings are based on test results and professional judgments, and that I may obtain a second opinion at my discretion.** I freely agree to this assessment. I understand that I am responsible for charges that are not covered under my insurance policy and/or charges that are incurred due to failure to inquire about or obtain pre-authorization, if applicable.

Name of Client Date

Signature Date
(Client or parent/legal guardian)

PSYCHOLOGY CENTER of IDAHO FALLS

Acknowledgement of Notice of Privacy Practices:

The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share you health records to run our business.
- We will use and share you health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of you health records.
2. You have the right to receive a list of who we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have had the opportunity to receive a copy of the Notice of Privacy Practices.

Signature: _____(of patient or legal representative)

Date: _____

Capacity of Legal Representative (if applicable)*:_____

Consent

I give Psychology Center of Idaho Falls my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Psychology Center of Idaho Falls Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Psychology Center of Idaho Falls has the right to change privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed. I understand that e-mail/FAX communication may be used for billing purposes.

Signature: _____

Date: _____

PSYCHOLOGY CENTER of IDAHO FALLS

Consent to Release Medical Information

Name of Client : _____ Date of Birth: _____

Information To Be Released: □ **Communication with Dr. Anderson or Dr. Harris**
□ **Psychological or Neuropsychological Testing Report**
□ **Other: _____**

Designated Person from whom information is being requested:

Name: ___**Carol V. Anderson, Ph.D.** ___**Aaron A. Harris, Ph.D.**

Address: **3670 S. 25th E. Suite 2**
Idaho Falls, ID 83404

Phone: **(208) 522-3404**

Name of Physician, Health Care Provider, Hospital and/or Other Designated Person authorized to communicate and/or receive records specified above:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Purpose of Disclosure: _____

Statement of Consent:

The undersigned does hereby authorize and consent to the disclosure of any and all information, records, documents, reports, clinical abstracts, histories and charts, of every kind and description, relating to the condition, care, confinement and treatment of the above-named patient, by the above-named individual or entity or their representative, to the above-named physician or physicians, health care provider, hospital, and/or other designated person(s), and does consent to the inspection and duplication of the indicated records by the same.

The undersigned further agrees to waive any and all privileges granted under the provision of law which may either directly or indirectly pertain to this disclosure as hereby authorized.

Signature_____

Date _____