PATIENT INFORMATION

Name (First, Middle, Last)	Age	Date of Birth (Required)

Address	City	State	Zip Code

Home Phone	Cell Phone	

Email Address

Emergency Contact Name: Relationship: Phone Number(s):

Relationship Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Primary Language(s): ☐ English ☐ Spanish ☐ Other:
First language learned: ☐ English ☐ Spanish ☐ Other:

Gender
☐ Male ☐ Female
☐ Other: _____

Ethnic Background: ☐ Hispanic ☐ Caucasian ☐ African American
☐ Native American ☐ Asian ☐ Other:

PERSON COMPLETING PACKET (IF DIFFERENT THAN ABOVE)

Name (First, Middle, Last)	Relationship to patient

Address	City	State	Zip Code

Home Phone	Cell Phone

Years you have known the patient	Your Age	Today's Date:

How often do you see the patient?
☐ Every day ☐ 2 – 3 days per week ☐ 4 – 6 days per week
☐ Once every 2 weeks ☐ Once per month ☐ Less than once per month

How many hours a week do you spend with him/her?

ADDITIONAL CONTACT INFORMATION

Email address: Can we send you e-mail messages? ☐ Yes ☐ No
**All email messages will come encrypted to protect confidential patient information*

Your preferred method of contact? ☐ Home ☐ Cell Phone ☐ Email
Who should be the primary contact person:

Name (First, Middle, Last)	Relationship to patient

Which is the best method to contact the above-named person?
☐ Home: ☐ Cell: ☐ Email:

Can we leave a message with the primary contact? ☐ YES, best method to leave a message: ☐ NO, don't leave a message please	☐ Home	☐ Cell Phone	☐ Email

POWER OF ATTORNEY		
Does the patient have a durable Health Care Power of Attorney? If yes, who is so named?	☐ Yes	☐ No
Does the patient have a durable Mental Health Power of Attorney? If yes, who is so named?	☐ Yes	☐ No

*IF YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, **PLEASE BRING A COPY** OF THE SUPPORTING DOCUMENTS TO THE INITIAL VISIT.*

GENERAL INFORMATION	
Has the patient had a consultation or work up forcurrent symptoms? ☐Yes ☐No If yes, please provide his/her contact information:	
Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

Does the patient have a primary care physician? ☐Yes ☐No If yes, please provide his/her contact information:	
Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

Neuropsychological Evaluation History	
Has the patient undergone a prior cognitive or Neuropsychological evaluation?	If so, when and where:
Please provide a copy of the prior evaluation if it was not performed at Mountainview Clinical Psychology or sign a release to provide authorization to request this.	

Note: Neurological records (your referring physician) are typically sent to Dr. Husk with your referral	

HEALTH INSURANCE INFORMATION

PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY.

PRIMARY INSURANCE	
Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	
Relationship to policy holder: ☐ Self ☐ Dependent ☐ Spouse/Partner (Member ID#:_____)	

PRIMARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)
Member's insurance toll free phone number:
Insurance notification/provider's toll-free phone:

SECONDARY INSURANCE	
Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	
Relationship to policy holder: ☐Self ☐Spouse/Partner (Member ID#: _____) ☐ Dependent	

SECONDARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)
Member's insurance toll free phone number:
Insurance notification/provider's toll-free phone:

CURRENT PROBLEM
What is the main reason for the person's visit to the clinic?
What were the person's initial symptoms and when did they develop?
When were these initial symptoms first observed?
Did the symptoms occur suddenly or develop gradually over time? ☐ Suddenly ☐ Gradually
Have the symptoms changed over time? ☐ Stable ☐ Stable, then sudden decline ☐ Steadily worsened ☐ Fluctuating ☐ Improved
Has the patient ever suffered symptoms of delirium? (periods of extreme confusion or disorientation due to illness, medication side-effects or being in the hospital) ☐ Yes ☐ No ☐ Don't Know If yes, please state the approximate year(s) and describe the event(s).

PEOPLE MAY EXPERIENCE CHANGES IN MANY ABILITIES. HELP US UNDERSTAND THE PERSON'S CURRENT ABILITIES BY MARKING THE BOXES BELOW.

MEMORY & THINKING – DOES SHE/HE HAVE PROBLEMS WITH:	Never	Sometimes	Often	Always
Recalling recent events	☐	☐	☐	☐
Recalling details of conversations	☐	☐	☐	☐
Repeating questions or stories	☐	☐	☐	☐
Misplacing or losing items	☐	☐	☐	☐
Forgetting dates, schedules, or appointments	☐	☐	☐	☐
Recognizing familiar places, people, or objects	☐	☐	☐	☐
Recalling events from the distant past	☐	☐	☐	☐
Learning a new route to an unfamiliar place	☐	☐	☐	☐
Becoming lost or confused in familiar places	☐	☐	☐	☐
Finding words or expressing thoughts	☐	☐	☐	☐

MEMORY & THINKING (CONTINUED)– DOES SHE/HE HAVE PROBLEMS WITH:

	Never	Sometimes	Often	Always
Understanding others	☐	☐	☐	☐
Making judgments or solving problems	☐	☐	☐	☐
Carrying out multi-step activities	☐	☐	☐	☐
Multitasking (performing two tasks at one time)	☐	☐	☐	☐
Focusing, concentrating, or being easily distracted	☐	☐	☐	☐

DAILY TASKS – DOES SHE/HE HAVE PROBLEMS WITH THESE ACTIVITIES (SPECIFICALLY RELATED TO CHANGES IN MEMORY & THINKING):

	N/A*	Never	Sometimes	Often	Always
Medications					
Preparing/organizing medications	☐	☐	☐	☐	☐
Recalling use and/or dosage	☐	☐	☐	☐	☐
Forgetting to take medications	☐	☐	☐	☐	☐
Making other medication errors	☐	☐	☐	☐	☐
Finances					
Preparing/completing taxes	☐	☐	☐	☐	☐
Organizing/preparing bill payment	☐	☐	☐	☐	☐
Bill payment (paying late or twice)	☐	☐	☐	☐	☐
Managing checkbook/online account	☐	☐	☐	☐	☐
Calculating a tip	☐	☐	☐	☐	☐
Making change	☐	☐	☐	☐	☐
Household Tasks					
Shopping or making purchases	☐	☐	☐	☐	☐
Cooking, grilling, or preparing food	☐	☐	☐	☐	☐
Household chores or simple repairs	☐	☐	☐	☐	☐
Doing laundry	☐	☐	☐	☐	☐
Arranging transportation	☐	☐	☐	☐	☐
Using a telephone	☐	☐	☐	☐	☐
Using technology (tools, microwave, thermostat, computer, smartphone)	☐	☐	☐	☐	☐

*Please check the N/A box if the person has never performed the task(s) or you do not know.

PERSONAL CARE AND GROOMING – HOW DOES SHE/HE COMPLETE THESE ACTIVITIES:	Completely Independent	Verbal reminders	Physical assistance	Completely Dependent
Shaving	☐	☐	☐	☐
Combing/styling hair	☐	☐	☐	☐
Brushing teeth	☐	☐	☐	☐
Applying or removing makeup, if applicable	☐	☐	☐	☐
Bathing or showering	☐	☐	☐	☐
Dressing or undressing	☐	☐	☐	☐
Eating using utensils	☐	☐	☐	☐
Chewing and swallowing correctly/safely	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐

JUDGMENT AND SAFETY - DOES SHE/HE HAVE PROBLEMS WITH:	
☐ Leaving the stove on or microwave fires	☐ Wandering off or getting lost
☐ Leaving the water on	☐ Forgetting to eat
☐ Having trouble regulating the thermostat	☐ Living alone or being left alone
☐ Having access to weapons or power tools	☐ Being susceptible to solicitors

Does the person currently drive a motor vehicle? ☐ Yes ☐ No

If he/she drives, are you concerned about his/her safety? ☐ Yes ☐ No

If you answered "Yes" to the question above, please check any of the following areas of concern.

☐ Drives too fast	☐ Gets angry or flustered	☐ Straddles lanes
☐ Drives too slow	☐ Turns in front of other cars	☐ Runs overs curbs
☐ Gets lost	☐ Hits/scrapes objects	☐ Doesn't pay attention
☐ Recent accidents/citations	☐ Trouble parking	☐ Other:

MOOD AND BEHAVIOR: Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Check the box only if the symptom(s) has been present **in the last month.**

	Not Applicable	Mild	Moderate	Severe
Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	☐	☐	☐	☐
Does the patient have hallucinations, such as false visions or voices? Does he/she seem to hear or see things that are not present?	☐	☐	☐	☐
Is the patient resistive to help from others at times or hard to handle?	☐	☐	☐	☐
Does the patient seem sad, or say that he/she is depressed?	☐	☐	☐	☐
Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax or feeling excessively tense?	☐	☐	☐	☐
Does the patient appear to feel too good or act excessively happy?	☐	☐	☐	☐
Does the patient seem less interested in his/her usual activities, or in the activities or plans of others?	☐	☐	☐	☐
Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them or saying things that may hurt people's feelings?	☐	☐	☐	☐
Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	☐	☐	☐	☐
Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?	☐	☐	☐	☐
Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?	☐	☐	☐	☐
Has the patient lost or gained weight, or had a change in the type of food he/she likes?	☐	☐	☐	☐

PERSONALITY AND BEHAVIOR:

Please check any of the following words that describe her/his life-long PERSONALITY:

☐ Even tempered	☐ Quick tempered	☐ Optimistic	☐ Pessimistic
☐ Socially outgoing	☐ Homebody	☐ Worrier	☐ Stubborn
☐ Low self-esteem	☐ Assertive	☐ Manipulative	☐ Complainer
☐ Hypochondriac	☐ Generous/caring	☐ Good sense of humor	

Has the patient experienced any CHANGES in personality or behavior, such as:

☐ Increased impulsivity	☐ Reduced frustration tolerance	☐ Increased irritability
☐ Agitation	☐ Difficulty getting started	☐ Reduced motivation
☐ Loss of empathy	☐ Socially inappropriate behavior	☐ Restlessness
☐ Risky behaviors	☐ Social withdrawal	☐ Other, describe:

SLEEP - DOES SHE/HE HAVE PROBLEMS WITH:

☐ "Acting out dreams" while sleeping (punching or flailing arms in the air, shouting or screaming)	☐ Legs repeatedly jerking or twitching during sleep (not just when falling asleep)
☐ A restless, nervous, tingly, or creepy-crawly feeling in legs that disrupts falling/staying asleep	☐ Walking around the bedroom or house while asleep
☐ Snorting or choking him/herself awake	☐ Seem to stop breathing during sleep
☐ Increased need for sleep	☐ Excessive daytime sleepiness/drowsiness
☐ Difficulty falling asleep	☐ Difficulty staying asleep

CAREGIVER CONCERNS-IF YOU ARE A CAREGIVER, WHICH OF THE AREAS BELOW CONCERN YOU?

Financial/legal	☐ YES	If yes, please describe
Physical health	☐ YES	If yes, please describe
Mental health	☐ YES	If yes, please describe
Managing problem behaviors	☐ YES	If yes, please describe
Decisions about alternative care options	☐ YES	If yes, please describe
Other	☐ YES	If yes, please describe

MEDICAL HISTORY

Check below if the patient has experienced any of the following?

☐ Head trauma or brain injury ☐ Loss of consciousness ☐ Stroke or TIA (mini-stroke)
☐ Difficulty walking, falls ☐ Exposure to toxins ☐ Brain infections
☐ Seizures ☐ Other neurological condition(s): If

you checked any of the above, description(s) and date(s):

Please list any birth injuries or illnesses:

Please list any childhood/adolescent injuries or illnesses:

Any history of learning disability or ADD/ADHD? ☐ Yes ☐ No
Did the patient ever repeat a grade or receive special education? ☐ Yes ☐ No
If yes to either of these questions, please describe:

Check below if the patient has the following conditions and/or is treated for the following conditions?

☐ High blood pressure ☐ Atrial fibrillation ☐ High cholesterol ☐ Diabetes
☐ Sleep apnea ☐ Other cardiac abnormalities

Has the patient had a brain scan? ☐ Yes ☐ No	
If yes, location:	Date:
Has the patient had a neuropsychological evaluation? (usually over 2 hours of testing of thinking skills) ☐ Yes ☐ No	
If yes, by whom:	Date:

MEDICATION HISTORY

ALLERGIES

Please list allergies to medications:

Please list allergies to foods:

Please list other allergies:

PLEASE LIST ALL MEDICATIONS TAKEN WITHIN THE LAST MONTH:

PRESCRIPTION MEDICATIONS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED
NONPRESCRIPTION MEDICATIONS, SUPPLEMENTS, VITAMINS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED

PLEASE LIST PAST AND CURRENT MEDICAL, NEUROLOGICAL AND PSYCHIATRIC PROBLEMS

PROBLEM	DIAGNOSIS DATE	ACTIVE
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SURGICAL HISTORY TYPE OF SURGERY	HOSPITAL	DATE

HOSPITALIZATIONS REASONS FOR HOSPITALIZATION	HOSPITAL	DATE

SYSTEM REVIEW

PLEASE REVIEW THIS AND CHECK "YES" FOR ANY SYMPTOMS THE PATIENT IS CURRENTLY EXPERIENCING

YES	CONSTITUTIONAL
☐	Chills
☐	Fatigue
☐	Fever
☐	Malaise (general discomfort)
☐	Night sweats
☐	Weight gain
☐	Weight loss

YES	HEAD, EYES, EARS, NOSE, THROAT (HEENT)
☐	Ear drainage
☐	Ear pain
☐	Eye discharge
☐	Eye pain
☐	Hearing loss
☐	Nasal drainage
☐	Sinus throat
☐	Visual changes

YES	RESPIRATORY
☐	Chronic cough
☐	Cough
☐	Known TB exposure
☐	Shortness of breath
☐	Wheezing
☐	Asthma

YES	CARDIOVASCULAR
☐	Chest pain
☐	Leg pain with walking
☐	Edema
☐	Palpitations (abnormal heart beats)

YES	GASTRO-INTESTINAL
☐	Abdominal pain
☐	Blood in stools
☐	Change in stools
☐	Constipation
☐	Diarrhea
☐	Heartburn
☐	Loss of appetite
☐	Nausea
☐	Vomiting

YES	GENITOURINARY
☐	Dribbling
☐	Burning with urination
☐	Blood in urine
☐	Excessive urination
☐	Slow stream
☐	Urinary frequency
☐	Urinary incontinence
☐	Urinary retention

YES	REPRODUCTIVE
☐	Erectile dysfunction (men)
☐	Penile/vaginal discharge
☐	Sexual Dysfunction
☐	Abnormal Pap smear (women)
☐	Breast discharge or lump (women)
☐	Painful menstrual periods (women)
☐	Pain with intercourse
☐	Hot flashes (women)
☐	Irregular menstrual periods (women)

YES	METABOLIC/ENDO
☐	Brittle hair
☐	Brittle nails
☐	Cold intolerance
☐	Hair changes
☐	Heat intolerance
☐	Excessive hair growth
☐	Excessive thirst
☐	Excessive eating

YES	NEUROLOGICAL
☐	Dizziness
☐	Extremity numbness
☐	Extremity weakness
☐	Walking or balance problems
☐	Headache
☐	Memory loss
☐	Seizures/convulsions
☐	Tremors
☐	Sudden loss of consciousness

YES	PSYCHIATRIC
☐	Anxiety
☐	Depression
☐	Insomnia

YES	SKIN
☐	Contact allergy
☐	Hives
☐	Itching
☐	Mole changes
☐	Rash
☐	Skin lesion

YES	MUSCULO-SKELETAL
☐	Back pain
☐	Joint pain
☐	Joint swelling
☐	Muscle weakness
☐	Neck pain

YES	HEMOTOLOGIC/ LYMPHATIC
☐	Easy bleeding
☐	Easy bruising
☐	Swollen glands

YES	IMMUNOLOGIC
☐	Environmental allergy
☐	Food allergy
☐	Seasonal allergy

PHYSICIAN NOTES

SOCIAL HISTORY

Highest level of formal education completed:

☐ Less than high school ☐ GED ☐ High school
☐ Some college ☐ Associate degree ☐ Bachelor's degree
☐ Master's degree ☐ Doctoral degree

Retired: ☐Yes ☐No If yes, year retired:

If working, current occupation:	If no longer working, prior occupation:
Years in current occupation:	Years in occupation:
Currently working: ☐ Part-time ☐ Full-time	Worked: ☐ Part-time ☐ Full-time

Hobbies/Interests

Does/did memory and thinking problems affect(ed) working or hobbies? ☐ Yes ☐ No

Number of living children: Number of daughters: Number of sons:

Current living situation:

☐ Alone in home/apt ☐ With spouse/significant other ☐ With other family or friends
☐ Assisted living ☐ Nursing home ☐ Other:

SUBSTANCE USE HISTORY

TOBACCO USE

Does the patient currently smoke? ☐ Yes ☐ No	
If yes: # of packs per day:	# of years smoked:
Did the patient ever smoke in the past? ☐ Yes ☐ No	If yes, year quit:
If patient ever smoked, # of packs per day:	# of years smoked:

ALCOHOL USE

Current use: How many drinks per week?

Past use: How many drinks per week?

Any history of excess use (now or in the past)? ☐ Yes ☐ No

SUBSTANCE USE

Has the patient used medical marijuana, recreational drugs, and/or misused prescription medications recently and/or in the past? ☐ Yes ☐ No

If yes:	Type:	Duration:

FAMILY HISTORY

DOES THE PATIENT HAVE A BLOOD RELATIVE WITH SYMPTOMS OF OR DIAGNOSIS OF:

Dementia/Senility/Alzheimer's? ☐ Yes ☐ No If yes, relationship and age of onset of memory problems:			
Parkinson's disease?	☐ Yes	☐ No	If yes, relationship:
Strokes?	☐ Yes	☐ No	If yes, relationship:
Psychiatric/Mental Illness?	☐ Yes	☐ No	If yes, relationship:
Intellectual disability?	☐ Yes	☐ No	If yes, relationship:
How many brothers: How many sisters:			
Does the patient have living siblings without dementia? ☐ Yes ☐ No			
Please list diseases/illnesses in your family:			
Mother:			
Father:			
Siblings: • Brothers: • Sisters:			
Children:			
Grandparents: • Mother's side: • Father's side:			

Mountainview Clinical Psychology, PLLC

Cancellation Policy & Patient Financial Responsibility

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: For value received, the undersigned guarantor and/or patient (hereinafter the "Responsible Party") promises to pay to Mountainview Clinical Psychology, PLLC all charges incurred for services rendered to the Responsible Party. The Responsible Party understands that Mountainview Clinical Psychology, PLLC will process the paperwork to complete insurance claim(s) but only as a courtesy to the Responsible Party, and the Responsible Party authorizes Mountainview Clinical Psychology, PLLC to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to Mountainview Clinical Psychology, PLLC. It is, however, understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by Mountainview Clinical Psychology, PLLC in the event insurance does not pay for these services. It is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Responsible Party. The Responsible Party authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized. The Responsible Party agrees to be bound by the terms and conditions of this account with Mountainview Clinical Psychology, PLLC.

Your copay is expected at the time of service. We will file the Responsible Party's initial insurance claim(s) and provide documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. In the event that the Patient's/Responsible Party's insurance does not cover our services (or any portion thereof), Mountainview Clinical Psychology, PLLC will work with the Responsible Party regarding payment (e.g., setting up a payment plan).

Responding to Forensic/Medical Legal requests, conferences and telephone calls with attorneys involve additional time and record keeping. The Responsible Party is responsible for all direct costs and expenses associated with Mountainview Clinical Psychology, PLLC and its attorney responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to court appearances, preparation of reports, photocopying, faxes, out of office travel, overnight delivery and courier services. These expenses are billed to the Responsible Party and to the Patient's/Responsible Party's Attorney. The Responsible party, however, remains responsible for payment of these charges if not paid in full within sixty (60) days.

Cancellation Policy:

Testing Appointments:

All testing appointments must be confirmed within 3 business days prior to the appointment. If we are unable to secure a confirmation from you within 3 business days of the appointment, your appointment will be cancelled and filled with another patient. **Be sure to respond to appointment reminder texts or phone calls to secure your appointment.** A minimum of 48 hours' notice is required for cancellation of confirmed testing appointments. These appointments are blocked off for large periods of time (3-4 hours), reserved only for the patient. If this notice is not received, the Responsible Party will be charged a no-show fee ($250 for neuropsychological evaluation) which was reserved for the appointment at the rates posted in the office of Mountainview Clinical Psychology, PLLC. Insurance will not be billed for missed/canceled appointments.

60-minute Intake/Feedback appointments:

A minimum of 24 hours' notice is required for cancellation of confirmed intakes/feedbacks. The no-show fee for confirmed intake/feedback appointments is $50.

If you have any questions, please speak with Dr. Husk/Dr. Mahan. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

Responsible Party: _____ Signature: _____

Date: _____

Guardian Signature (if patient unable to sign**): _____

CONSENT FOR NEUROPSYCHOLOGICAL SERVICES
Mountainview Clinical Psychology, PLLC
14300 N. Northsight Blvd., Ste. 215 Scottsdale, AZ 85260
P: 623-414-3279. F: 855-850-8159

This consent form is to request the voluntary evaluation of:

_____

Patient Name Date of Birth

by Mountainview Clinical Psychology, PLLC, (Dr. Kristi Husk)

Referral Source: You have been referred for a neuropsychological evaluation (i.e., evaluation of your thinking abilities) by _____.
(Physician Who Referred You)

Nature and Purpose of Evaluation:
A neuropsychological evaluation consists of review of records, interview, and cognitive and psychological testing. I understand that the purpose of this evaluation is to provide information about me for the purposes of diagnosis and treatment planning/recommendations.

The goal of this neuropsychological evaluation is to help you, your treating providers, family, and qualified third parties gain a better understanding of your cognitive strengths and weaknesses and/or determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive functions as well as emotional and behavioral functioning.

Evaluation is helpful in identifying specific diagnostic considerations and treatment recommendations. Neuropsychological tests are designed to evaluate brain-behavior relationships and help to determine if any changes have occurred in your attention, memory, language, problem solving, visual-spatial abilities, or other cognitive functions. A neuropsychological evaluation may point to changes in brain function and suggest possible methods and treatments.

Evaluation Process: In addition to an interview in which I will be asking you questions about your background and current medical symptoms, I may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, viewing printed material, and manipulating objects. True-false and self-report emotion and personality questionnaires may also be included. Supplementary records from hospitals, treating physicians, professional providers, schools, as well as interviews with designated family, care providers, and individuals who know you well may be included with your consent.

The interview typically takes 45-60 minutes. Depending on the referral questions, testing can range from as little as 1.5 hours to as much as 4 hours. You will be given breaks as needed and requested. Once the tests are administered, the data analyzed, and relevant records reviewed, you will be provided with feedback to discuss the results and recommendations. Afterwards, the results will be incorporated into a written report that explains the test findings, diagnostic considerations, and recommendations.

Psychometrists: I understand that Ms. Anisa Basen is a psychometrist. Psychometrists are professionals who specialize in administering and scoring psychological tests and assessments. I understand that Mr. Mason Stewart is a Psychology Doctoral trainee under the supervision of Dr. Husk. Ms. Basen or Mr. Stewart may be involved in the administration of your testing, interview, and/or feedback.

By signing this form, I am agreeing to allow the Doctoral trainees and psychometricians to administer assessment measures under the supervision of Dr. Husk.

Foreseeable Risks, Discomforts, and Benefits: For some individuals assessments can cause fatigue, frustration, and anxiousness about performance. Benefits associated with this assessment include gaining a better understanding of your current strengths and weaknesses, developing a plan to use your strengths to work with or accommodate your weaknesses, and identifying treatment that is specific to your needs. We can take steps to ensure your comfort, such as discussing the procedures ahead of time, so you know what to expect, and taking frequent breaks.

Fees and Time Commitment: A typical evaluation includes the time spent directly with you and others who are interviewed. It also includes additional hours for reviewing records, scoring and interpreting the tests, providing feedback, and report preparation. This comprehensive evaluation process is estimated to take 6-8 hours of time.

Payment and Assignment of Benefits: Though the fees are generally covered by insurance, patients are responsible for any and all fees for the evaluation not covered by insurance, including but not limited to deductibles, coinsurance, and copays.

Confidentiality: The records concerning this evaluation will be retained by Mountainview Clinical Psychology, PLLC and will be kept confidential. No information will be released (other than to designated referring third parties where applicable) without prior written consent, except in the case of a medical emergency, to secure payment for treatment from health insurance plan or other third-party payment system, or as permitted by law.

Under the following circumstances, the law requires or permits that information be disclosed:

(1) When there is reasonable suspicion of child abuse or neglect, or evidence of elder abuse.
(2) When a person presents an imminent or potentially serious danger to self or others.
(3) In the event of certain court orders, including subpoenas for judicial arbitration or mediation.

Release of Information: By signing the acknowledgement and consent form below, you agree to the release of both oral and written information to the referring party. **In order to release information to individuals other than the referring party, you must sign a separate written consent form authorizing the release of the requested material to the designated party.**

By signing below, I am authorizing payment of benefits to Mountainview Clinical Psychology, PLLC payment of services is thereby directed to them. Mountainview Clinical Psychology, PLLC may need to send information to the insurer to obtain payment for this evaluation.

By signing this form, I acknowledge that I, or my legal designee, have read and understood the above, that any questions I had were satisfactorily clarified and understood, and that I consent to the described services and limitations of confidentiality.

Signature_____ Date_____

Printed Name_____

Please **read and initial** the following disclaimers to acknowledge your understanding :

-

____ I understand that this is a clinical evaluation. The purpose is to evaluate my cognition for medical reasons. It is not intended or sufficient to support litigation.

____ I understand that if I have ongoing litigation and/or have legal representation related to a connected personal injury, we can't see you for a clinical evaluation. I confirm that I don't have such litigation or legal representation.

____ I understand that it is important that I put forth my best effort. If I don't it will be detected in the data and the results will be invalid.

____ I understand that completion of the report summary will take two weeks, so I should schedule any follow up appointments with my neurologist or other doctors to review these results at least two weeks after my appointment.

____ I understand that anything I share with the doctor may be included in the report summary.

____ I understand that Mountainview Clinical Psychology, PLLC does not determine disability or work status, or complete forms, but will share my test results upon my request with the entities who make these decisions.

Signature_____Date_____

Printed Name_____

MCP, PLLC CREDIT CARD ON FILE POLICY

PATIENT INFORMATION FOR CREDIT CARD ON FILE POLICY
Mountainview Clinical Psychology, PLLC 14300 N. Northsight Blvd. #215 Scottsdale, AZ 85260

As you are aware, healthcare has undergone dramatic changes in the past few years. High-deductible health plans are now a mainstay in the healthcare landscape. This means that more responsibility of payment is being placed on patients. We need to be sure that patient balances are paid in a timely manner. If you have ever stayed in a hotel or rented a car, you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due. As of January 1, 2022, MCP, PLLC has adopted a Credit Card on File Policy.

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored securely. Once we receive your Explanation of Benefits (EOB) (what the insurance company will pay towards your visit), we will wait 30 days to allow you time to pay the balance on your account. If your balance is not paid, your credit card will be charged for the outstanding balance that is your responsibility. Co-pays must be paid at the time of visit. If you have any questions about this payment method, please do not hesitate to call our Billing Office at 623-.

How does credit card on file benefit me?
Using credit card on file, you will be able to:
- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts sent via email

Please note that all of your rights with respect to the use of your credit card will remain in effect. This new policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment. Your credit card on file can be used for the following reasons:
-Visit payments not collected from you at the beginning of the visit
-No show or late cancellation charges
-Insurance discrepancies
-Outstanding balance greater than 31 days past due

Credit Card Type (circle) **Visa** **MasterCard** **Discover** **Amex**

Credit Card Number:_____Security Code:_____Exp Date_____

Name as it appears on card:_____ Zip code:_____DOB: _____

Phone Number:_____

I authorize MCP, PLLC to charge the credit card above per the terms of this policy. This authorization shall remain in effect until MCP,PLLC has received written notification from me of its termination.

Signature:_____ Date:_____
The credit card number will be redacted prior to scanning this form into the Electronic Medical Record.

MCP, PLLC CREDIT CARD ON FILE POLICY

PATIENT INFORMATION FOR CREDIT CARD ON FILE POLICY

What is a deductible and how does it affect me? An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the health insurance company begins to pay for any services. This works just like the deductible for your car or homeowner's insurance policy.

When do I have to pay for services? You, the patient, are ultimately responsible for all charges any time you receive medical care. You are expected to pay in full for your services until your deductible and any applicable co-insurance is met.

How will I know when my deductible has been met? How will I know how much you are going to charge me? You can call your insurance company at any time to check on how much of your deductible has been met. Some insurance companies provide this information on-line. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay when they send you an Explanation of Benefits (EOB). We look at your EOB carefully to determine the amount that is to be paid by you, the patient. That is called the Balance Due.

But I always pay my bills, why me? We have to be fair and apply the policy to all of our patients. Keeping a credit card on file makes the check-out process easier, faster and more efficient and helps you to take care of the amount that you may owe.

What about identity theft and privacy? Under HIPAA, we are under strict rules and guidelines in terms of protecting patient privacy, and the credit card is considered protected health information. Credit card numbers are encrypted and stored securely. No credit card numbers are stored at our practice.

What if I don't have a credit card? You are welcome to leave a HSA (Health Savings Account), Flex Plan, or Debit card on file or pay with cash or check for our standard visit cost. We understand there are legitimate reasons you may not have a credit card. In that case, we will work out a payment plan for you. Payment for service is due upon receipt of your billing statement after your insurance plan processes your claim. If your account remains unpaid, subsequent statements will be sent to the address we have on file. When your balance is 90 days past due, your account will be turned over to a collection agency and will be assessed a $50.00 release fee. You will be dismissed as a patient from our practice.

When will my card be charged? We will submit your claim to your health insurance company if applicable. Once your insurance company processes your claim, you will have 30 days upon receipt of your billing statement to pay the amount due in any manner you wish. If you do not pay the amount due within 31 days, your credit card will be charged the Balance Due.

What if I have two insurance plans? Even with two insurance plans, you may still owe a small balance that is your responsibility to pay.

MCP, PLLC CREDIT CARD ON FILE POLICY

How will I know that you have charged my credit card? How do I get a receipt? You will receive an email receipt when your credit card is charged.

Is this the same as "signing a blank check"? No. Credit card on file is similar to what a hotel or rental car company does at check-in. All credit card contracts give cardholders the right to challenge any charge against their accounts.

Is this "Balance Billing"? No. "Balance Billing" is asking the patient to pay the difference between our fee and what is contracted with your insurance company. This is a breach of our contracts. The charge to your credit card is only the patient responsibility. For example, you see one of our providers at MCP, PLLC and incur a charge fee of $200. We have a contract with your insurance company that states we will accept a payment of $100 for the visit. The insurance company agrees to only pay 80% of that amount. Your responsibility (as the patient) is the remaining $20 which will be charged to your credit card. We cannot charge you the difference between the charged fee and the contracted fee.

What charges will my card be used for? Your credit card will be used only when a balance becomes due.

What if my card is declined or expired? We will contact you to update the information. If your account becomes delinquent, you will be sent to collections.

What if I want to change the credit card on file? You can give us your new credit card number at any time.

What if I need to dispute my bill? We will work with you to understand if there has been a mistake. We will refund your credit card if we or your health insurance company has made a billing error.

When do I give you my credit card? We ask that you complete the Credit Card Authorization Form. This agreement will apply to all family members under your account. Once we have entered your credit card information into our financial institution's encrypted system, the credit card information will be destroyed. Our staff will only be able to see the last 4 digits. You can also deliver your credit card information over the phone or by mail. What if I have more questions? Our staff is happy to speak with you about your account at any time. Please call our Billing Office at 623-414-3279

MOUNTAINVIEW CLINICAL PSYCHOLOGY, PLLC
KRISTI HUSK, PSY.D., ABN, CBIS

14300 N. Northsight Blvd. Ste. 215, Scottsdale, AZ 85260
p 480-280-6618 f 855-850-8159

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Full Name) **(Date of Birth)**
hereby authorize the release of my health information

To/from:

Mountainview Clinical Psychology, PLLC
14300 N. Northsight Blvd., Suite 215
Scottsdale, AZ 85260
Fax: 855-850-8159 Phone: 623-414-3279

To/from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: _____

Information requested: _____

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not redisclose my medical record to another party without further written consent. I will not hold Dr. Husk nor Mountainview Clinical Psychology, PLLC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Husk for clarification of the information therein.

Date: _____ **Signature:** _____
(Patient or Legal Representative)

Date: _____ **Witness:** _____

HIPAA NOTICE OF PRIVACY PRACTICES & PATIENT CONSENT

Mountainview Clinical Psychology, PLLC/Kristi L. Husk, Psy.D., ABN, CBIS
14300 N. Northsight Blvd., Ste. 215
Scottsdale, AZ 85260

Your Privacy Rights
Your health information is personal and will be kept confidential. We use and disclose your protected health information (PHI) for treatment, payment, health care operations, and other uses allowed by law. We will not share your health information without your consent except as required or permitted by law.

Use and Disclosure of Your Health Information We may use and share your PHI to:

- Treat you and coordinate your care (with your providers or specialists)
- Obtain payment from insurance or third-party payers
- Conduct clinic management and operations

Other disclosures of your PHI require your written authorization, which you may revoke in writing at any time.

Your Rights You have the right to:

- See and request copies of your health information
- Request corrections to your health records
- Request restrictions or limits on certain uses or disclosures
- Receive an accounting of disclosures
- Complain if you believe your rights have been violated. For patients who wish to file a HIPAA complaint, the recommended contact information to include on your form is for the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). Patients can file a complaint using any of the following methods:

Mailing Address:	Office for Civil Rights, HHS 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201
Phone:	1-800-368-1019 (Toll-Free) 1-800-537-7697 (Hearing Impaired)
Email:	OCRComplaint@hhs.gov

Consent and Acknowledgment By signing below, you acknowledge that you have received, read, and understand this Notice of Privacy Practices. You consent to the use/disclosure of your PHI as described for treatment, payment, and health care operations.
You understand that:

- You may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it.
- Refusal to sign does not affect your right to treatment.
- Once information is disclosed by your authorization, it may be redisclosed by that party and may no longer be protected by HIPAA.

Patient Name: _____ Date of Birth:_____

Patient Signature: _____Date: _____

If representative: Name/Relationship: _____