



📞 Office: 910-585-2167

📠 Fax: 910-705-4847

[info@thetestingpsych.com](mailto:info@thetestingpsych.com)

[www.thetestingpsych.com](http://www.thetestingpsych.com)

 Fill this out by hand

### Note

Fill out this questionnaire at your own convenience. Your answers are saved as you go, so you don't need to finish it all in one sitting. Submit the form only when you have answered all that you can.

## Assessment Need and Financial Screening Worksheet


Welcome! A quick overview - before you start, this form is an introductory worksheet to ensure we are a good match for your clinical needs and financial considerations. As you work through worksheet, you will have the opportunity to opt out at any time, or continue on to a self-schedule link for an initial intake appointment to discuss more about your needs. Initial intakes are billable to medical insurances for which I am a provider, or at a fee-for-service cost.

Dr. Maybouer offers two broad areas of psychological assessment:  
Neurodevelopmental/Psychological and School-Related.

 Neurodevelopmental/Psychological Assessments:

Cognitive, developmental, and/or some social-emotional concerns, such as autism, ADHD, intellectual disabilities, or depression and/or anxiety. These are frequently covered by health insurance plans as “medically necessary.”

**Dr. Maybouer is an “in-network” provider for Tricare East, Blue Cross/Blue Shield of NC, and First Carolina Care. More information follows, but please be aware a credit card or deposit must be on file for ALL clients, even those utilizing insurance.**

 School-Related Assessments Including learning disabilities (such as dyslexia), giftedness, or early kindergarten admission.

Achievement /educational testing is not considered "medically related" by health insurance plans and are excluded from their coverage plans.

Thank you for interest. I hope to work with you :) !



Sara Maybouer, PhD

Licensed Psychologist

Nationally Certified School Psychologist

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**Please indicate who is being REFERRED for assessment (e.g., please put your CHILD'S name if completed by parent/guardian; your own name if you are an adult client).**

First Name (OF PERSON TO BE TESTED. For example, CHILD'S NAME IF PARENT IS COMPLETING) \*

Middle Name \*

Last Name (OF PERSON TO BE TESTED. For example, CHILD'S NAME IF PARENT IS COMPLETING) \*

Date of Birth (OF PERSON TO BE TESTED. For example, CHILD'S NAME IF PARENT IS COMPLETING) \*

M/D/YYYY	
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Gender (OF PERSON TO BE TESTED. For example, CHILD'S NAME IF PARENT IS COMPLETING) \*

☐ Female ☐ Male

Street Address (OF PERSON TO BE TESTED. For example, CHILD'S NAME IF PARENT IS COMPLETING) \*

Apt./Unit #:

City: \*

State: \*

Zip Code: \*

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Please indicate who is **COMPLETING** this form (must be parent/legal guardian over age 18):

What is the name of person completing this form: \*

Mobile Phone (of person/parent/guardian of person referred for psychological assessment): \*

Your Relationship to person referred for assessment:

☐ Self ☐ Mother ☐ Father ☐ Legal guardian ☐ Stepparent ☐ Other

Email (of parent/guardian of person referred for psychological assessment): \*


Referral Source: How did you hear about Dr. Maybouer? \*

# Assessment Need/Referral Question

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Please indicate the type of assessment for which you are referred or interested:

 **Neurodevelopmental/Psychological Assessments**

 **School-related (please be reminded medical insurance does not cover educational/academic/school related assessment) \***

☐  Attention (ADHD, Executive Functioning/organizational skills)

☐  Autism/Developmental Delay

☐  Social-Emotional/Behavioral (depression, anxiety, oppositional defiance)

☐  \*School-Related (learning disability, AIG/gifted, early kindergarten)

☐ Other (please describe)

If "other(s)", please specify

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In your own words, what are the top 2-3 specific referral questions you'd like addressed through testing? (e.g., Does my child have autism? Can you help us access school services such as an IEP)? \*

## Financial Info

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**ALL clients - even those utilizing health insurance - are REQUIRED to securely upload a credit card number to be kept on file, for fees, such as co-pays, deductibles, and no shows or late cancellation fees as outlined in the Informed Consent contract, and for noncovered services, such as academic-related testing and fee-for-service deposits and payments.**

**The reasons for this policy is two-fold:**

- 1) A credit card on file minimizes the risk of "no shows" for scheduled appointments, which can quickly destabilize a solo practitioner in private practice. I've actually never had to run anyone's card, since thankfully, no one has no-showed knowing the policy!**
- 2) I was already, but especially in our COVID era, am largely a paperless practice, which includes handling cash and checks. It's much easier for invoicing and bookkeeping purposes, especially for deductibles, co-pays or other out-of-pocket fees not covered by health insurance.**

**Please indicate if you understand and would accept the credit card requirement if/when we proceed with scheduling. \***

- ☐ I understand credit card requirement policy.
- ☐ No, can do. Will bail out from here.

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**If hoping to use insurance, the following Primary Insurance information is required for claims to be filed. All boxes must be completed.**

**Note: The "insured/sponsor" is the person who is the policy holder - for a child being tested, this would be the parent or guardian whose name is on the insurance policy).**

**Primary Insurance Company \***

**Insurance Plan (e.g., TRICARE Prime, Select, Retired, For Life, etc)**

**Who is the person being tested - what is their relationship to the person who is insured (the client is the person being tested; the insured is the person whose name is in the insurance policy) ) \***

- ☐ Child being tested under parent's policy
- ☐ Myself (I am the person being tested and my name is on the policy)
- ☐ Spouse is being tested under spouse's policy ☐ Other

Member ID / Policy # \*

Group Number

Insured/Sponsor Name \*

Insured/Sponsor Gender \*

- ☐ Female ☐ Male

Insured/Sponsor Phone # \*

Insured/Sponsor Date of Birth \*

M/D/YYYY	
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Insured/Sponsor Street Address \*

Insured/Sponsor City \*

Insured/Sponsor State \*

Zip Code \*

It is your responsibility to verify and know your insurance policy coverage and benefits; an outline of suggested questions to ask your insurance provider is provided below. Be reminded benefits and authorizations are estimates, not a guarantee of coverage or payment. You will be responsible for any amount not paid for by insurance, including all copays, co-insurance, and deductibles, at the time of service. UNFORTUNATELY, NO ACADEMIC/ACHIEVEMENT TESTS OR SCHOOL-RELATED ASSESSMENTS ARE BILLABLE TO MEDICAL HEALTH INSURANCE!

Have you already received an referral letter with an authorization number through your health insurance? \*

☐ Yes ☐ No

If yes, please enter the authorization number: \*

Referring Provider

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**If hoping to use insurance, please UPLOAD A PIC/COPY (FRONT AND BACK) of your insurance card (DEERS card for Tricare).**



Select File(s) to Upload

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**The fine print:**

**Always know your plan and cost-sharing responsibilities! I will attempt to check your benefits, coverage, and authorizations prior to beginning services, but you are ultimately responsible for knowing your coverage and costs and are responsible for all charges.**

**In order to determine coverage and your estimated share of costs for services, you are highly encouraged to contact your insurance company at the phone number listed on your insurance card or through their patient portal. The following questions can be a helpful guide to understand your coverage:**

**Be sure the representative is telling you about your mental health (sometimes called behavioral health) benefit, not your medical benefits. If there's a specific number for mental health benefit information on the back of your card, use that. Here's useful information to know about your policy coverage:**

Ask, "Are my behavioral health benefits administered by a separate behavioral health company (e.g., Magellan for BCBSNC)?"

☐ Yes ☐ No

If Yes: what is the contact information for that company (reference number, customer service name, phone number, etc.). Contact them for the next questions.

Can you confirm that Dr. Sara Maybouer (Tax/EIN # 47-4275062 and NPI #1023383890) is an in-network provider for my plan?

Ask, "Do I have a deductible?"

☐ Yes ☐ No

Ask, "Is there an individual deductible, family deductible, or both?"

☐ Individual ☐ Family ☐ Both

If yes to individual deductible, "what is the deductible amount ?

"How much of my individual deductible has been met?"



If yes to family deductible, "what is the family deductible?"

"How much of my family deductible has been met?"

"After I meet my deductible, what percentage of the visit cost will I be reimbursed for?"

"Do I have a copay to see a specialist?"

☐ Yes ☐ No

If yes, "What is my copay amount per visit to see a specialist?"

"What is my annual maximum benefit?"

These are too many details I can't find out; I'll roll the dice and sign the waiver of financial responsibility! \*

☐ Information is gathered as best I know ☐ Roll the dice

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**Even if you have health insurance, policies vary widely for behavioral health coverage, including psychological assessments, ranging from no coverage, to only a certain numbers of hours or billing codes with only certain tests (e.g., ABA updates through Tricare). Some policies may require me to present a proposed testing plan before they will authorize coverage.**

**The following are helpful questions you can ask your insurance carrier specifically about coverage specifically for psychological testing/assessment:**

	Yes	No	Explain
Again, these are too many details I can't find out; I'll roll the dice and sign the waiver of financial responsibility!	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Is psychological/neuropsychological testing covered by my plan?			
Has any other psychological testing been done within the past year to affect my coverage?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Does my insurance require a referral from my medical provider to consult with a specialist such as Dr. Maybouer?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
After a referral is made to the psychologist for consultation, does the psychologist have to then obtain authorization for a testing plan?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Is there a maximum number of hours for psychological testing covered by my plan? If yes: How many hours can be billed?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Is there a limit to the dollar amount that can be billed for psychological testing? If yes: What is the dollar limit?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
If you are seeking testing for a learning disability (Not ADHD/ADD), ask: Is psychological testing covered as medically necessary if it is to determine if there is a learning disability?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Are specific tests and procedures required for some evaluations (for example, autism)? If yes, what tests are required?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Can some suspected diagnoses be denied cognitive evaluation and instead required to use less time/cost consuming efforts (for example, does ADHD evaluation allow for cognitive testing, or just a clinical interview?)	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

## Consent Forms and Scheduling

**Would you like to proceed with self-scheduling the initial TELEHEALTH parent/adult intake appointment to discuss your assessment needs and what COVID-era assessments are like?**

**If yes, you will be linked to a series of consent forms for review and signature.**

**The link to self-schedule can be found by clicking “intake” and searching for available dates/times. Please let me know if nothing seems to match your schedule and we’ll find some alternatives!**

**<https://thetestingpsych.intakeq.com/booking> \***

- ☐ Yes, schedule intake billable to my insurance. Credit card must be on file.
- ☐ Yes, schedule intake at out-of-pocket cost billable to credit card on file.
- ☐ No scheduling at this time; please keep file open for later use.
- ☐ No scheduling; please close my file.

Please include any other information we may need for registration. Thank you 😊

## e-signature

Please sign to indicate who completed this form.

[Clear](#)

[Type instead](#)

**Submit Signature**

By signing this form electronically, and clicking on "Submit Signature", you are agreeing to the terms stated herein.

 Sign Out



Submit Form