

JAY SCHNEIDERS, Ph.D., ABPP
Clinical Neuropsychology & Clinical Health Psychology

Patient's Name: _____ Date: _____ 201__

Patient's address: _____

City: _____ State _____ Zip _____

Phone: : (H) _____ (C) _____ (W) _____

May we leave messages on the above *home* number? Yes No On the above *cell* number? Yes No

Date of Birth: _____ Age _____ Soc. Sec. # _____ - _____ - _____

single married divorced separated widowed life partner

partner/spouse/caregiver/parent's name: _____

Patient's employer: _____
 Homemaker Employed full-time Employed part-time Student Disability status

Who referred you to Dr. Schneiders? _____

Name of Insured if different from patient: _____

Other insured's date of birth _____ Soc Sec #: _____

Other insured's employer: _____

Type of insurance held: Medicare Medicaid TriCare other none

Is your condition a result of an accident or injury? yes no unsure

If yes, date of injury: _____ **Are you involved in any lawsuits?** Yes No

Did your attorney ask you to get this examination or evaluation? Yes No

Your **attorney's** name and firm, if any: _____

Name of **primary insurer:** _____

Policy number _____ group number _____

Name of **secondary insurer:** _____

Policy number _____ Group number _____

Acknowledgement of financial responsibility: I understand it is my responsibility to ensure that I have all the necessary referrals and preauthorizations for my care from Dr. Schneiders. *I understand Dr. Schneiders and his practice manager cannot guarantee amount or degree of reimbursement from my insurers, if any.* The information above is accurate and true to the best of my knowledge. I understand I am responsible to pay for services rendered, including attorneys' fees and costs of collection in the event of a default. I understand that my account becomes delinquent after 60 days. I also authorize Dr. Schneiders to furnish any/all information concerning my illness/condition and treatments to my insurance carriers/Medicare/Medicaid, to my referring doctor(s) or clinician(s), and to providers to whom he may refer me for additional care or evaluation. I authorize my insurance company to send payment directly to Dr. Schneiders.

Signature _____ Date: _____

STRICTLY CONFIDENTIAL

To my patients:

Thank you for taking the time to complete these many pages.

While I understand that paperwork and forms like these are time-consuming, they will very much help me stream-line and shorten the time we need to meet together, and will make your evaluation with me better focused and much more complete.

(In general, when people fill out these forms in advance, I find we can shorten their appointment by an hour or more on average.)

Not every question here will apply to every patient's condition. However, a broader understanding of who you are as a person, and what you have experienced or gone through in your life will help me better understand you as the individual you are, no matter what symptoms may be bothering or affecting you more specifically.

Thank you in advance for your cooperation and assistance.

And finally, as a reminder, if you have questions about your insurance coverage or billing issues, please feel free to call my office manager, Sandy, at 303-697-4086 at any point along the way.

I look forward to meeting you and hope I will be able to help you with your problems or concerns.

-- Dr. Jay Schneiders

STRICTLY CONFIDENTIAL

Goals For Your Consultation / Evaluation With
Dr. Schneiders

Why are you coming in for a consultation with Dr. Schneiders at this time?

(Please check all that apply:)

- I decided to come in for an evaluation by my own decision or request, and for my own specific reasons.
- I have no idea why I was referred, or what I am supposed to see Dr. Schneiders about.
- My Dr. _____ told me to see a neuropsychologist.
- My family member(s) wanted me to see a neuropsychologist.
- My supervisor, boss or my work wanted me to get evaluated.
- My lawyer or attorney wanted me to get evaluated.
- My insurance company told me they wanted this evaluation done.
- Other:

What are your own personal goals for this examination or consultation?

(Please check all that apply:)

- I need an evaluation before I undergo surgery (for example, Deep Brain Stimulation surgery for Parkinson's disease or other condition)
- I want to find out why I am having problems with my thinking, memory, etc. and see if they can be helped better than they have been so far.
- I need to have an examination before I can get disability.
- I need disability paperwork filled out.
- I need to have an examination before I can go back to work or school.
- I need to have an examination for a lawsuit or court-case.
- I want a second opinion or another opinion about my condition or problems.
- I want to get my [driver's or pilot's] license back.
- Other:

STRICTLY CONFIDENTIAL

History of Present Illness or Problem

Being *as specific as you can*, please try to pinpoint

the very first month and year [_____ / _____]
you *began* to have **memory, thinking or cognitive changes** or problems,
or that you, or your family, or others, *first noticed them changing for the worse*.

If you yourself do not see or think you have any memory difficulties or problems with your thinking, but people you know, or your family, or doctor think(s) so, check here: []

Did *memory, thinking and/or cognitive* problems seem to come on

[] **all at once** or [] **slowly/gradually** or [] **Does not apply**

Have your *memory, thinking and/or cognitive* problems or changes

[] **stayed about the same** [] **become worse over time?** or [] **Does not apply**

If your problems have become worse over time, has this change been

[] **rapid/fast** [] **slow/gradual** [] **happening in steps**

Are your *memory or other cognitive and thinking* problems

[] **sometimes better and sometimes worse – they fluctuate or vary at times**
[] **or, pretty much the same day-to-day** or [] **Does not apply**

If your memory or other thinking problems seem to fluctuate or wax and wane

[] **During or throughout the day** [] **Worse at nighttime** [] **From day-to-day**

If your memory or other thinking problems do seem to fluctuate, on your **best day now**, do you think you are ever able to function at your earlier, 100% best?

[] **Yes** [] **No** [] **Not sure**

Have you or people you know or your family noticed any changes in your personality during this time – are you acting or feeling or behaving differently from how you did before?

[] **Yes** [] **No** [] **Not sure**

If yes, what kinds of changes have been noted? (Please circle any that apply)

Anger outbursts Moodiness Irritability Lack of Motivation Impulsivity Apathy Other

STRICTLY CONFIDENTIAL

Please indicate which of the following areas or problems are present for you now:

___Memory Problems

- ___ I am just generally more forgetful (where I put things, etc.)
- ___ I have to make lists or write things down now to remember where I didn't used to
- ___ I forget conversations I've had now that I wouldn't have before
- ___ I have forgotten periods of time from my own life
- ___ I forget people's names more often than I used to
- ___ I forget words I used to know easily while I'm talking
- ___ I forget what I'm doing in the middle of things now
- ___ Other:

___Attention & Concentration Problems

- ___ I have a hard time focusing on, or tracking, things like reading, conversations, television, etc.
- ___ I get lost or derailed in the middle of conversations now
- ___ I space out at times and lose track of what's going on around me
- ___ I get distracted more easily now than I used to

___Speech & Language Problems

- ___ I have more trouble speaking as clearly as I used to
- ___ I have more trouble finding the words I want to say
- ___ I have more trouble getting the right word out though I know what I want to say
- ___ I say the wrong word by accident, rather than the one I wanted to say
- ___ I have more trouble writing as clearly or well as I used to
- ___ I have more trouble understanding what I read than I used to
- ___ I have more trouble understanding what people *say* than I used to
- ___ Other:

___Perceptual Visual-Spatial Problems

- ___ I have more trouble seeing clearly and well
- ___ I have more trouble hearing clearly and well
- ___ I have more trouble finding my way around or get lost now in familiar places
- ___ I have new or worse problems figuring out directions (or telling right from left)
- ___ I have trouble at times finding or seeing things that are actually right in front of me
- ___ Other:

___General Thinking and Cognitive Problems

- ___ I'm not as organized than I used to be when I do things
- ___ I have trouble now following through and finishing things I start
- ___ I get confused while I'm working on things or doing something now
- ___ I have more trouble planning things than I used to
- ___ I get confused about things now that I didn't before
- ___ I am having new or more trouble with numbers, figures, arithmetic than I did before
- ___ My thinking and information processing speed is much slower than it used to be.

___Driving: [] I am driving at this time [] I am not driving now

- ___ I have had a ticket or an accident or a fender-bender in the last year.
- ___ I feel completely safe driving and my family and doctor agree with me about that.
- ___ I feel completely safe driving, but my family and/or a doctor does *not* think that I am.

STRICTLY CONFIDENTIAL

Do other people (family or friends) *see your cognitive, medical, and psychological concerns and/or your problems the same way* you do? Yes No Unsure

Which of these kinds of specialists have you ever seen? Check all that apply even if you aren't sure:

- Neurologist
- Neurosurgeon
- Psychiatrist
- Clinical Psychologist for psychotherapy or counseling
- Neuropsychologist for memory/cognitive testing
- Mental health or substance abuse counselor or social worker
- Pain specialist
- Sleep doctor
- Physiatrist (rehabilitation doctor)
- Cardiologist (heart doctor)
- Endocrinologist (for diabetes or thyroid)
- Transplant doctor
- Nephrologist (kidney doctor)
- Hepatologist (liver doctor)
- Oncologist (cancer doctor)
- Rheumatologist
- Homeopath
- Chiropractor
- Speech therapist
- Massage therapist
- Other:

Which of the following tests have you had?

- MRI of the brain CT scan of the brain PET or SPECT scan
- EEG (a test of the brain, not heart) DaT brain scan
- Memory testing [a few minutes long; several hours long]
- Biopsy of _____
- Psychological Testing (personality or IQ testing; MMPI. etc.)
- Sleep study – “polysomnogram” – (This is an overnight study.)

Do you have a medical marijuana certificate? yes no I've applied for one
Doctor's name who prescribed, if so:

Do you use marijuana to help treat your medical issues and problems? Yes No

If yes, do you use Edible marijuana or Smoking marijuana or Both

STRICTLY CONFIDENTIAL

Please check all that apply:

seizures or epilepsy	___me	___family member
Parkinson's disease	___me	___family member
tremor	___me	___family member
Huntington's disease	___me	___family member
dementia or Alzheimer's disease	___me	___family member
multiple sclerosis	___me	___family member
stroke or TIA or subdural bleed	___me	___family member
hypertension/high blood pressure	___me	___family member
diabetes	___me	___family member
thyroid disease	___me	___family member
cancer	___me	___family member
heart disease	___me	___family member
liver disease	___me	___family member
kidney disease	___me	___family member
autoimmune disease	___me	___family member
brain aneurysm or bleed	___me	___family member
brain tumor	___me	___family member
schizophrenia	___me	___family member
bipolar disorder /manic depression	___me	___family member
head injury/concussion	___me	___family member
asthma	___me	___family member
sleep apnea	___me	___family member
restless leg syndrome	___me	___family member
COPD	___me	___family member
atrial fibrillation or flutter	___me	___family member
heart attack or heart failure	___me	___family member
alcohol or drug problem	___me	___family member
chronic pain	___me	___family member
suicide attempt	___me	___family member
psychiatric hospital stay	___me	___family member

Are there any **other accidents, surgeries, or medical problems** you have had or suffered from? If so please list those here. You may continue on the back of this page if you need to:

STRICTLY CONFIDENTIAL

What medications are you currently taking? Please list over the counter and/or all supplements or herbals here as well. (You may bring Dr. Schneiders a list instead of writing meds down here, but also use the other side of this page to continue if necessary.)

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

_____ Dose _____ #Times a day: _____

Are you having any concerning or serious side effects to any medications at this time?

Yes No Unsure

STRICTLY CONFIDENTIAL

Neuropsychological Issues: History

Were there any complications around or during your birth you know of?

Yes **No** **Unsure**

Did you suffer any problems or delays as a child in learning to

read, **write**, **walk**, or **talk** **None of these**

Did you suffer from a learning disability or problems learning in any subjects?

Yes **No** **Unsure** If so, please describe:

Were you ever in special education or tutoring? **Yes** **No**

Were you ever held back, or jumped ahead a grade? **Yes** **No**

Have you ever had a concussion, been knocked out, or had a traumatic brain injury?

Yes **No** **Unsure**

Have you ever been exposed to a toxic chemical such as pesticides, inhalants, agent orange or other? **Yes** **No** **Unsure**

Do you *usually* feel well rested when you awaken in the morning? **Yes** **No**

Please check all that apply:

I have had a sleep study done at some time in the past.

People sometimes tell me I stop breathing when I'm asleep for short times

I snore at night. Other people say I snore.

Sometimes I awaken myself gasping a little bit or snoring.

My legs or body move around during the night when I am sleeping or trying to sleep.

I'll sometimes feel like I wake up while I'm still asleep and feel paralyzed.

I talk or walk in my sleep. I have nightmares and/or very vivid, intense dreaming.

I feel sleepy during the day. I nap during the day sometimes.

I have trouble getting to sleep I fall asleep in quiet activities like TV or reading.

I have trouble staying asleep and sleeping through the night.

I have been prescribed CPAP, BiPAP, ViPAP or some other sleep device: **Yes** **No**

IF YES:

I am unable to tolerate it and cannot use it. I never got it set up.

I use it about 1-3 hours a night. I use it between 3-6 hours a night.

I use it throughout the entire night.

I use it once or twice a month. I use it once or twice a week.

I use it 4-5 times a week. I use it every night.

STRICTLY CONFIDENTIAL

Early History

How many brothers _____ and how many sisters _____ do/did you have?

Have any of your siblings died? **Yes** **No** **Unsure**

How would you describe your childhood overall and in general?

___ **Easy and happy** ___ **Sad, hard, or painful** ___ **Other:** _____

Did you experience any of the following?

emotional abuse in childhood **Yes** **No**
sexual abuse or rape in childhood **Yes** **No**
physical abuse or beatings in childhood **Yes** **No**

emotional abuse in adulthood **Yes** **No**
physical abuse in adulthood **Yes** **No**
sexual abuse, rape or trauma in adulthood **Yes** **No**
assault in adulthood **Yes** **No**
other traumas not mentioned here **Yes** **No**

[If you experienced any of those events, do you ever have unwanted memories, thoughts or feelings about them that come over you sometimes?]

Yes **No** **Does Not Apply**

[Do you have nightmares about them? **Yes** **No** **Does Not Apply**]

What kind of student were you overall: **good** **poor** **average**

I usually earned or received grades in the **A B C D F** range, overall.

I was not a very good student but I could have been.

School was hard for me even though I tried and worked hard.

Check all that apply:

- I completed high school
- I dropped out but *finished* the _____ grade.
- I earned my GED
- I graduated from high school
- I completed _____ years of college
- I completed _____ years of trade or business school
- I earned the following degrees _____

STRICTLY CONFIDENTIAL

Did you ever serve in the military? ___Yes ___No

If so, which branch? [] USA [] USN [] USMC [] USAF [] Coast Guard

If so, did you ever see active duty / combat? ___Yes ___No

If so, what kind of discharge did you receive? ___Honorable ___General ___Other

If so, do you have any service connected disability? ___Yes ___No _____%

Do you speak any languages other than English? ___Yes ___No

What is your *primary* (or *first* spoken) language? _____

What jobs have you held, including being a homemaker or stay-at-home parent?

What is the title of your job *now*, or *last* full time job _____

Do you work at the present time? [] Yes [] No [] Does Not Apply

If so, are your cognitive or memory problems affecting your work or school work?

[] Yes [] No or [] Does Not Apply

Are you on disability? ___Yes ___No If yes, [] medical [] psychiatric

Are you applying for disability? ___Yes ___No ___Not sure

Are you retired? ___Yes ___No If yes, what year? _____

Are you married or in an intimate partner relationship at this time? ___Yes ___No

If married or in a committed partner relationship now, for how long? _____

Have you been married before? [] Yes [] No [] If yes, how many times before? _____

Have you any children? ___Yes ___No If so, ages: _____

How would you describe your *social support and friendship network* of people in your life?

[] I have many close friends

[] I don't have any friends I'm close to

[] I have a few close friends

[] I keep pretty much to myself

What sort of things do you do for fun or give you pleasure in your life?

Have you ever been arrested or convicted of a crime other than a minor (**non-DUI**) traffic offense, or done any time in jail, prison or juvenile detention? [] Yes [] No

STRICTLY CONFIDENTIAL

Mood and Other Symptoms

Please check any and all that apply:

- I feel reasonably happy or good most of the time.
- I have the normal mix of good days and bad days most people have.
- I don't seem to have many feelings at all these days, up or down.

- I feel sad or depressed most of the day, most days
- I have thoughts of suicide and sometimes I am afraid I might act on them.
- I have thoughts of suicide but know I would never act on them.
- I have felt or been suicidal at one or more times in the past.
- I don't feel as interested in or get as much pleasure from things and people as I used to.

- I have moments when I get panicky all of a sudden.
- I get startled very easily or more easily than I think most people do.
- I feel anxiety or nervousness nearly all the time that really doesn't ever let up.
- Sometimes I have to say, think or do special things to keep something bad from happening.
- I have a terror of closed-in places (such as MRIs), or of needles, or of something else
I try to avoid if at all possible because it's so scary.
- I have some behaviors or actions I think are (or others have called) "obsessive" or
"compulsive" or "OCD"

- Sometimes I hear things around me other people do not hear (sounds, voices, music, etc.)
- Sometimes I see things around me other people do not see.
- Sometimes I taste or smell things around me other people don't.

- I have mood swings that last more than a few hours or a day.
 If yes, my mood swings are quick and sudden, or slow and gradual

- I have worried I might be "bipolar" or "manic depressive" or someone else has told me that
they think I am.
- Sometimes I feel so good or "up" that I go days without sleep, or with only a very little sleep.
- My mind sometimes races extremely fast, or jumps from thing-to-thing-to-thing very quickly.
- Sometimes I have trouble controlling my impulses, which could or does get me into trouble.
- Sometimes my speech becomes really fast and pressured for days at a time.

- I sometimes have angry outbursts.
- My anger outbursts are only verbal (yelling, saying angry things)
- Sometimes my anger outbursts are physical (throwing, hitting, etc.)
- Sometimes I get so angry that I think or worry I could possibly hurt or injure
someone if things got out of hand.

- Sometimes things around me don't feel real, even though I know they are.
- Sometimes I feel disconnected from or 'out of sync' with my body.
- I have moments when I seem not aware of what is going on around me; when I seem
to "click off."

STRICTLY CONFIDENTIAL

Personal Habit Checklist

Caffeine:

How much caffeine do you take in every day?
_____ cups of coffee _____ cups of tea _____ caffeinated sodas/colas _____ other

Tobacco:

Do you currently smoke? [] **Yes** [] **No** How much a day if so? _____
How many years if yes? _____
Do you chew tobacco? [] **Yes** [] **No** How much a week if so? _____
Did you smoke in the past but quit? [] **Yes** [] **No** When did you quit? _____
How many years if yes? _____

Alcohol:

Do you drink alcoholic beverages? [] **yes** [] **no** [] **I used to but I don't anymore.**

If you drink now, how many drinks do you have *on an average day*?

[] more than 24 [] 13-24 [] 9-12 [] 5-8 [] 3-4 [] 1-2

If you drank in the past but not now, how many drinks did you have *on your average day*?

[] more than 24 [] 13-24 [] 9-12 [] 5-8 [] 3-4 [] 1-2

On your heaviest day of drinking in the past year, how many drinks did you have?

[] more than 24 [] 13-24 [] 9-12 [] 5-8 [] 3-4 [] 1-2

On your heaviest day of drinking during your life, how many drinks did you have?

[] more than 24 [] 13-24 [] 9-12 [] 5-8 [] 3-4 [] 1-2

What kind of beverages do or did you drink? [] beer [] wine [] mixed drinks [] hard liquor

Have you ever had a DUI or DWAI? [] **Yes** [] **No**

If yes, when? _____ How many times? _____

Have you ever attended AA or any other alcohol or drug treatment program? [] **Yes** [] **No**

Other:

Which of the following substances have you used or do you currently use?

	<u>Current/Now</u>	<u>In the past</u>
[] marijuana/pot	[] yes [] no	[] yes [] no
[] cocaine	[] yes [] no	[] yes [] no
[] heroin	[] yes [] no	[] yes [] no
[] methamphetamine/uppers/speed	[] yes [] no	[] yes [] no
[] MDMA – ecstasy –“Molly”	[] yes [] no	[] yes [] no
[] hallucinogens/LSD/mushrooms	[] yes [] no	[] yes [] no
[] IV drugs of any kind - “needles”	[] yes [] no	[] yes [] no
[] other: _____		

Have you ever been *treated* for an alcohol or drug use problem? [] **yes** [] **no**

Have *you* ever *worried* you might have had an alcohol or drug use problem? [] **yes** [] **no**

Has *anyone else* ever said to you they felt you had a drug or alcohol use problem? [] **yes** [] **no**

Have you ever had a problem with prescription drugs or an addiction to them? [] **yes** [] **no**

STRICTLY CONFIDENTIAL

Psychological Care History

Have you ever been seen for detailed memory and cognitive testing or neuropsychological examination before? Yes No Unsure

Have you ever seen any of the following mental health professionals at any time in the past, for care or for an evaluation?

Psychologist (PhD, PsyD)

Psychiatrist (MD, DO)

Other psychotherapist (LCSW/MSW, LPC, MA, etc.) or substance/alcohol use counselor or therapist (CAC, etc.).

I have never been in therapy, or had any mental health care in the past.

Are you currently receiving any mental health care from anyone? Yes No

Have you ever been hospitalized psychiatrically in the past? Yes No

Have you ever been administered electroconvulsive shock therapy (ECT)?
 Yes No If yes, what year(s) _____

Please circle any of the following medications you have been prescribed in the past, whether you are currently taking them or not:

Antidepressants	Anti-anxiety medications	Antipsychotic medications				
Sleeping pills	Prozac/fluoxetine	Zoloft/sertraline	Celexa/citalopram			
Lexapro	Paxil	Elavil/amitriptyline	nortriptyline	Haldol	Seroquel	
Abilify	Risperdal	Zyprexa	Clozapine	Pristiq	Thorazine	Mellaril
Luvox	Xanax/alprazolam	Valium/diazepam	Ativan/lorazepam	BuSpar		
Klonopin/clonazepam	Ambien/zolpidem	Lunesta	Rozerem	Sonata		
Aricept/donepezil	Exelon	Namenda	Lithium	Depakote	Wellbutrin	Cymbalta

___Other medicine(s) not mentioned for mood, anxiety, thinking, sleep:

STRICTLY CONFIDENTIAL

Colorado Patient Rights Information /

HIPAA Acknowledgment

The State of Colorado mandates that patients be given the following additional information at the start of psychological care:

Dr. Schneiders' credentials:

Doctoral degree in Clinical Psychology, University of Colorado – Boulder, 1985
Colorado License for the Independent Practice of Psychology, #1152
Board Certification in Clinical Health Psychology, ABPP - Certificate #4771
Board Certification in Clinical Neuropsychology, ABPP - Certificate #6449

General information:

The practice of psychologists is regulated by the Colorado Division of Registrations: Board of Psychologist Examiners, 1560 Broadway Avenue, #1350, Denver, CO 80202. Phone: 303 – 894 – 7800.

As to the regulatory requirements applicable to mental health professionals: **A Licensed Psychologist must hold a doctorate degree in psychology and have at least one year of post-doctoral supervision. An ABPP Board Certified Psychologist must additionally have several years post-graduate training and education in the specialty, and then pass national written and oral examinations in that specialty conducted by peers in the specialty area.**

[A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is *not* licensed or certified, and no degree, training or experience is required. A licensed Psychiatrist must hold a medical or osteopathic degree, and have completed a one year internship and a residency in psychiatry.]

Psychology, like medicine, is not an exact science. Neuropsychological and clinical health psychology assessment involves interview, and frequently, tests and procedures which attempt to assess a person's functioning in various arenas: for example, memory, concentration, reasoning, personality function, effort, visual-spatial perception and motor coordination among others. For optimal benefit, these require maximum cooperation and active effort on the patient's part.

You are entitled by law to receive information about methods of assessment and treatment, the nature of any clinical techniques used, the duration of planned care (if known), and about your doctor's fee schedule.

You may always seek a second opinion, and may terminate any elective treatment with any practitioner at any time.

Dr. Schneiders strongly endorses the position that in a relationship with *any* health care professional – psychologist, psychiatrist, physician, chiropractor, therapist or other – sexual intimacy is *never* appropriate, and should be reported to the individual's respective licensing, registration or certification board. (Such activity is unethical and/or illegal.)

Your communications with a psychologist are confidential, although *you should be aware that rare exceptions exist under certain conditions* (described in the more extensive information form provided for

STRICTLY CONFIDENTIAL

you and detailed in the HIPAA Notice of Privacy Rights). Some of these exceptions are listed in Section 12-43-218 and the Notice of Privacy Rights you were provided, and there are other exceptions in Colorado and Federal law. For example, psychologists are required to report child abuse to authorities. If such an extremely rare legal exception arises during therapy, where feasible, you will of course be informed.

Caregiver/Next of Kin/ Relatives with whom you authorize us to discuss your account information with, if necessary: _____

Billing Office Information/Financial Policy: *For any questions, please call Sandy at 303-697-4086.* If we are on your insurance plan, we are pleased to bill them for your office visit. However, if you do not have insurance, payment for services are due at the time they are rendered. Our office accepts cash, checks, Mastercard and Visa. Returned checks, and letters to you which require Certified Mail, will be subject to a \$25.00 service charge. Charges *may* be made for telephone calls with the doctor over 10 minutes in length, additional medical reports, medical records, and in the case of not showing for appointments and for appointments cancelled without 24 hours notice, unless unavoidable illness, hospitalization, storm conditions, etc. make it impossible to make a scheduled session. If for any reason, your insurance company denies your claim, we will make reasonable efforts to help you to appeal that denial if you wish, but you are ultimately responsible for all charges for services rendered. In the extremely unlikely event of collection agency involvement, I acknowledge that the information provided to Dr. Schneiders and his office by me is true and correct to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and 100% costs of collection in the event of a default. I authorize Dr. Schneiders or his staff to furnish or obtain any and all information concerning his work with me with collection or other agencies affiliated with his practice in the extremely unlikely case of a defaulted claim.

I have read the preceding information and I understand my rights as a patient or as the patient's legally responsible party.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS FORM AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature _____ Date _____

Printed Name: _____

[Person Signing for the Patient, If Any _____

Relationship to the Patient _____

Are you the legal guardian or legal conservator appointed by the Court for this patient?

[] Yes [] No [] Unsure or [] Does Not Apply]

STRICTLY CONFIDENTIAL

Authorization to Exchange Records

This form, when completed and signed by you, authorizes Dr. Schneiders to release and exchange protected information from your clinical record to a person or persons you designate.

I authorize Dr. Jay Schneiders, and/or his practice manager Sandy Valentine, to release & exchange information about my medical/surgical/neuropsychological history, conditions, test results, examinations and status. This may include information regarding my drug and alcohol history, if any, mental health treatment and conditions, and/or HIV/AIDS or Huntington’s disease status if known.

This information may be released to and exchanged with the following doctors, hospitals and/or others:

- 1) Referring doctor: _____
- 2) PCP: _____
- 3) Other doctors, psychotherapist, etc.: _____

- 4) Hospital(s) or Facilities: _____
- 5) Other: _____
- 6) Other: _____

I am authorizing release and exchange of this information *at my request* and of my own free will. This authorization shall remain in effect: *until I withdraw my permission to release and exchange this information in writing*, or other: _____

I have the right to revoke this authorization, in writing, at any time by sending written notification to Dr. Schneiders’ office. However, my revocation will not be effective to the extent that Dr. Schneiders has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer be protected by the HIPAA Privacy Rule.

Signature of Patient

Date

Signature of Patient’s Representative

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority legally to act for the patient must be provided.

Follow-up Exam Results Review Sessions

Following your assessment (“testing”) session, it will take Dr. Schneiders a certain amount of time to analyze your results, integrate them with your medical information and reports, and complete his own report, which is typically comprehensive and lengthy. He sees one or more patients each day, each of whom requires such a thorough report.

For that reason, we ask you *not* schedule follow-up appointments with your referring doctor for 2-3 weeks to discuss your neuropsychological exam results, *unless you need to see that doctor for any other important medical reason*. Dr. Schneiders does his best to get a full, written analysis and report to referring doctors 2-3 weeks following your appointment with him.

My next appointment with my referring doctor is _____.

Dr. Schneiders also believes that your own clear, detailed understanding of the results of your examination is an extremely important aspect of your neuropsychological work-up.

For that reason, unless you expressly decide not to return for feedback, he asks you phone the office following your examination and schedule a one-hour follow-up session for a review and discussion of your results at a mutually convenient time. At that appointment – to which Dr. Schneiders encourages you to bring family members or others importantly involved in your life and care – he will discuss your results, give you a copy of his report, and discuss treatment recommendations and options.

Sometimes, Dr. Schneiders will require further clinical reports or data (prior neuropsychological test data, MRI reports, etc.) before being able to complete his own analysis, and in those cases, he will let you know this at the end of your meeting with him, so you can schedule your follow-up sessions both with him and with your referring doctor in a realistic and optimal time frame.

If you have questions about follow-up or review sessions, please feel free to ask us at any time and we will try to address issues that involve special timing needs, scheduling options, etc., to the best of our ability.

Please indicate your preference below:

I will call the office and schedule a regular follow-up session to review my assessment results in person with Dr. Schneiders.

I prefer Dr. Schneiders just mail me a copy of his report, and I will call him if I have any questions after receiving it.

I prefer Dr. Schneiders just send a copy of his report to my referring doctor. I do not wish to schedule a follow-up session or to receive a copy of his report.

Other: _____