 Jay Schneiders, PhD ABPP

**Complex Case Neuropsychology**

3601 SOUTH Clarkson Street, Suite 530 - Englewood, CO 80113 – 720-587-7173

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

We greatly appreciate your courtesy and assistance…

Your appointment and care are important to us!

**Your referring doctor or clinician needs this evaluation to help you with the problems and symptoms you are suffering with and/or are worried about.**

**We understand when absolutely unavoidable things come up at the last minute (an illness or severe weather conditions) that make it impossible to come in for the time you have scheduled, but we earnestly request that you check your schedule again now and make certain the appointment time you have arranged at our office will work for you:**

***Please* be sure you haven’t inadvertently scheduled other appointments or activities for the time we have set aside to see you. (Our office will be unable to fill appointment times with other patients who need to see Dr. Schneiders if yours is cancelled at the last minute unless we have at least 48 hours’ notice.)**

**A CHECKLIST FOR YOUR MEETING WITH DR. SCHNEIDERS:**

*Please fill this list out and* ***bring it with you to your appointment with your completed paperwork****:*

[ ] I have completely filled out the attached pre-meeting paperwork and have it with me.

[ ] I am seeing Dr. Schneiders at his **3601 S. Clarkson Street, Suite 530** office.

**Be sure *not* to google the office address! The correct *current* address is this one.**

**Detailed map & directions are on Dr. Schneiders’ website: drjschneiders.com.**

[ ] I understand there will be a one hour lunch break for appointments that are scheduled to extend from morning until the afternoon.

[ ] I understand there is no restaurant in or very close to Dr. Schneiders’ office.

*My lunch arrangements are:*

[ ] I will be able to drive myself to get lunch.

[ ] The person coming with me will drive me to get lunch.

[ ] I am bringing my lunch with me and will eat it there [in the office waiting

room or down the street in the park].

[Unfortunately, we do not have public wi-fi, microwave or refrigerator available in our building.]

JAY L. SCHNEIDERS, Ph.D., ABPP

**3601 SOUTH CLARKSON STREET, SUITE 530** - Englewood, CO 80113

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2024

Patient’s address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: : (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ok to leave messages on my email? **[ ] Yes [ ]No** Ok to leave messages on my: [ ]Home [ ]Cell

My email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Soc. Sec.# XXX-XX-\_\_\_ \_\_\_ \_\_\_ \_\_\_

[ ] single [ ] married [ ] divorced [ ] separated [ ] widowed [ ] life partner

Partner/spouse/caregiver/parent’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or [ ] None

[ ] Homemaker [ ] Employed full-time [ ] Employed part-time [ ] Student [ ] Disability [ ] Unemployed

Who referred you to Dr. Schneiders?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured *if different from patient*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Other insured’s* date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc Sec #: XXX-XX- \_\_\_ \_\_\_ \_\_\_ \_\_\_

*Other insured’s* employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your condition a result of an accident or injury? [ ] Yes [ ] No [ ] Unsure**

**If yes, date of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you involved in any lawsuit? [ ] Yes [ ] No**

**Did an attorney ask you to get this examination or evaluation? [ ] Yes [ ] No**

I consider myself: [ ] Hispanic-American [ ] African-American [ ] Caucasian [ ] Asian-American

[ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] I prefer not to say.

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 pre-authorizations for my care from Dr. Schneiders. *I understand Dr Schneiders and his practice associates, Rhea, and/or ABC Billing, 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 reasonable attorneys’ fees and 100% costs of collection in the event of a default. I further understand that my account becomes delinquent after 60 days. I also hereby authorize Dr. Schneiders/staff to furnish any/all information to my insurance carriers/Medicare/my referring doctor(s) or clinician, concerning my illness, condition, and treatments. I authorize my insurance company to send payment directly to Jay Schneiders, PhD, ABPP.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2024

To my patients:

Thank you very much for taking the time to complete these many pages before coming in for your appointment!

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

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

Not every question here will apply to every person’s condition. However, a broader, deeper 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.

I also suggest that you take a few minutes to look at my website:

**drjschneiders.com**

On it you may find answers to questions you might have about your appointment with me and about what a neuropsychologist is and does.

And finally, as a reminder, if you have questions about your insurance coverage or billing issues, please feel free to call my office manager, Rhea, at 720-587-7173 at any point along the way.

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

*-- Dr. Jay Schneiders*

Goals For Your Consultation / Evaluation

With Dr. Schneiders in 2024

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

*(Please check all that apply:)*

[ ] I am coming in for an evaluation by my own decision or request, and for

my own specific reasons.

[ ] I do not know 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) wants me to see a neuropsychologist.

[ ] My supervisor, boss or my work wants me to get evaluated.

[ ] My lawyer or attorney wants me to get evaluated.

[ ] My insurance company told me they want 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, or other epilepsy/seizure surgery).

[ ] 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:

**History of Present Illness or Problem**

Being *as specific as you can*, please try to pinpoint *the month and year that you first 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 think you have any memory difficulties or any 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 [ ] Both have occurred**

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 for me all the time now.**

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

**[ ] 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 days now,** do you think you are ever able to function at your previous, 100% mental/cognitive usual and typical best?

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

Have you, or have other people you know, or has your family, noticed any significant changes in your *personality* during this time – that is, 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:**

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

\_\_\_\_**Memory Problems**

\_\_\_\_I am generally more forgetful (where I put things, etc.).

\_\_\_\_I need 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’ve forgotten periods of time from my own life or important things that happened to me or that I did.

\_\_\_\_I forget people’s names more often than I used to.

\_\_\_\_I have more trouble holding ideas or thoughts in my head for more than a moment or two.

\_\_\_\_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 frequently lose my train of thought.

\_\_\_\_I get distracted more easily now than I used to.

**\_\_\_\_Speech & Language Problems**

\_\_\_\_I have more trouble speaking as clearly or well as I used to be able to.

\_\_\_\_I have more trouble *finding* the words I want to say.

\_\_\_\_I have more trouble *pronouncing* familiar words at times.

\_\_\_\_I sometimes *say the wrong word by accident*, rather than the one I wanted to say.

\_\_\_\_I have more trouble writing as clearly or as well as I used to.

\_\_\_\_I have more trouble [ ] *understanding* what I read and/or [ ] *retaining* what I read.

\_\_\_\_I have more trouble understanding what people say to me.

\_\_\_\_Other:

**\_\_\_\_Perceptual, Visual-Spatial Problems**

\_\_\_\_I have trouble seeing clearly and well.

\_\_\_\_I have trouble hearing clearly and well.

If yes, [ ] I have had a hearing test. [ ] I have not had my hearing tested

\_\_\_\_I have tinnitus [ringing or buzzing sound] in [ ] both ears. [ ] in one ear.

\_\_\_\_I have trouble [ ] finding my way around, and/or [ ] getting lost at times in familiar places.

\_\_\_\_I have problems [ ] figuring out directions, and/or [ ] telling left and right.

\_\_\_\_Other:

**\_\_\_\_General Thinking and Cognitive Problems**

\_\_\_\_I’m not as organized as I used to be when I do things.

\_\_\_\_I have more 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 have trouble shifting from one thing to another (and back) and keeping track of things when I do.

\_\_\_\_I am having more trouble with numbers, figures, arithmetic than I did before.

\_\_\_\_My thinking and information processing speed is slower than it used to be.

**\_\_\_\_\_Driving:** [ ] I am driving at this time. [ ] I am not driving now. *[please check* ***all*** *that apply:]*

\_\_\_\_I have had, and am having, no problems driving at all.

\_\_\_\_I have had a ticket or an accident or a ‘fender-bender’ in the last year.

\_\_\_\_I feel safe driving, but my family does *not* think that I am.

\_\_\_\_A doctor or health care provider has told me not to drive.

**Current Living Situation: [ ] I am happy with my current living situation.**

**[ ] I am not happy about my current living situation.**

[ ] I live by myself in my own home, condo, or apartment.

**or**

[ ] I live with my spouse/partner [ ] with other family [ ] with a roommate.

[ ] I live in Independent Living.

[ ] I live in Assisted Living

[ ] I live in a Group Home, Halfway House, or other residential setting.

I have some sort of home health care assistance (someone comes in to help me with my cooking, cleaning, or other aspects of my care): **[ ] Yes [ ] No**

**Which of these kinds of specialists have you ever seen? Please check all that apply even if unsure.**

\_\_\_Neurologist [MD or DO]

\_\_\_Neurosurgeon [MD or DO]

\_\_\_Psychiatrist [MD or DO]

\_\_\_Clinical Psychologist for psychotherapy or counseling [PhD or PsyD]

\_\_\_Neuropsychologist for memory/cognitive testing in the pasts [PhD or PsyD]

\_\_\_Mental health or marriage counselor or social worker [LPC, LCSW, MA]

\_\_\_Substance use/abuse counselor [CAC]

\_\_\_Pain specialist [MD, DO or PhD/PsyD]

\_\_\_Sleep doctor [MD, DO or PhD/PsyD]

\_\_\_Physiatrist (rehabilitation doctor) [MD or DO]

\_\_\_Pastoral Counselor [Rev., Father, Rabbi, Imam, M.Div.]

\_\_\_Homeopath

\_\_\_Chiropractor [DC]

\_\_\_Speech therapist [MS-CCC/SLP]

**Which of the following tests have you had?**

\_\_\_MRI of the brain \_\_\_CT scan of the brain \_\_\_ PET or SPECT brain scan

\_\_\_EEG (a test of the brain, *not* heart) \_\_\_ DaT brain scan

\_\_\_Memory testing \_\_\_a few minutes long and/or \_\_\_several hours long

\_\_\_Biopsy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Psychological Testing (personality or IQ testing; MMPI. etc.)

\_\_\_Sleep study or “polysomnogram.” (This is an overnight study.)

Do you have a medical marijuana certificate? [ ] yes [ ] no [ ] I’ve applied for one.

Doctors who prescribed, if so: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use marijuana/cannabis to help treat your medical issues and problems? **[ ] Yes [ ] No**

***If* yes,** do you use [ ] *Edible* marijuana [ ] *Smoking* marijuana [ ] *CBD / oil*

*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 / Alzheimer’s disease \_\_\_me \_\_\_family member

Multiple Sclerosis \_\_\_me \_\_\_family member

stroke or TIA or brain bleed \_\_\_me \_\_\_family member

brain surgery and/or brain shunt \_\_\_me \_\_\_family member

loss of sense of taste or smell \_\_\_me

hypertension/high blood pressure \_\_\_me

high cholesterol \_\_\_me

diabetes [ ] Type I [ ] Type II \_\_\_me

thyroid disease \_\_\_me = [ ] hypothyroid [ ] hyperthyroid

cancer \_\_\_me [type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

heart disease \_\_\_me

liver disease or liver transplant \_\_\_me

kidney disease or kidney transplant \_\_\_me

sepsis/severe body infection \_\_\_me

autoimmune disease \_\_\_me [type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Fibromyalgia \_\_\_me

Arthritis \_\_\_me [ ] Rheumatoid/RA [ ]Osteoarthritis

Menopause [date of onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] \_\_\_me

brain aneurysm / brain bleed \_\_\_me \_\_\_family member

brain tumor \_\_\_me \_\_\_family member

schizophrenia \_\_\_me \_\_\_family member

bipolar disorder /manic depression \_\_\_me \_\_\_family member

head injury/concussion/TBI \_\_\_me \_\_\_family member

asthma/reactive airway disease \_\_\_me

sleep apnea \_\_\_me \_\_\_family member

narcolepsy \_\_\_me \_\_\_family member

restless leg syndrome \_\_\_me

COPD / lung disease \_\_\_me

atrial fibrillation or flutter \_\_\_me

heart attack or heart failure \_\_\_me

Covid-19/Corona Virus infection \_\_\_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

anorexia or bulimia (past or present) \_\_\_me \_\_\_family member

Please list any ***other*** **accidents**, **surgeries**, or **medical problems** you have had or suffered from**. If necessary, please continue on the back of this page**.

**What medications are you currently taking?** Please list over the counter and/or all supplements or herbals here as well. (You may bring a list of meds instead of listing here and may 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 problematic or unpleasant side effects to any medications at this time?

[ ] Yes [ ] No [ ] Unsure

**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, ADD/ADHD, or problems learning any subjects?

**[ ] Yes [ ] No [ ]Unsure If Yes, Type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Were you ever in special education, speech therapy or ever need tutoring? **[ ] Yes [ ]No**

Were you ever [ ] held back a grade? or [ ] jumped ahead a grade? or [ ] I was neither.

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 *without protection*?  **[ ] 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: [ ] home study [ ] study in sleep lab

[ ] 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 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 in my sleep

[ ] I walk in my sleep. [ ] I have nightmares. [ ] I have very vivid, intense dreaming.

[ ] I act out my dreams sometimes while I’m still asleep. [ ] I wake up confused sometimes.

[ ] I feel sleepy during the day. [ ] I fall asleep in quiet activities like TV or reading.

[ ] I nap during the day sometimes. [\_\_\_\_\_\_average #days per week. \_\_\_\_\_\_average hours per nap.]

[ ] I have trouble falling asleep

[ ] I have trouble staying asleep and sleeping through the night.

[ ] I often wake up some hours before I want to and then can’t get back to sleep.

I have been prescribed CPAP, BiPAP, ViPAP, and/or Oxygen 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 about 3-6 hours a night.

\_\_\_\_I use it throughout the entire night. \_\_\_\_I use it about once or twice a week.

\_\_\_\_I use it about 4-5 times a week. \_\_\_\_I use it every night.

\_\_\_\_I use it when I nap. \_\_\_\_I use it when I travel

**Early History**

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

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

If yes, who and from what cause(s):

How would you describe your childhood *overall* and *in general*?

**[ ] Easy and happy [ ] Sad, hard, or painful [ ] Emotionally Mixed**

**Did you experience any of the following?** Neglect? **[ ]Yes [ ] No**

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 or rape in adulthood **[ ] Yes [ ] No**

Other assault in adulthood  **[ ] Yes [ ] No**

Other traumas not mentioned above **[ ] Yes [ ] No**

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

**[ ] Yes [ ] No [ ] Does Not Apply**

[*If* you experienced any of those events, do you ever feel like you are reliving it or them – having a ‘flashback’**? [ ] Yes [ ] No [ ] Unsure [ ] Does not apply ]**

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

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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 think I could have been.

[ ] School was hard for me even though I tried and worked hard at it.

Check all that apply:

[ ] I completed high school

[ ] I dropped out before graduating 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 [ ] nursing school

[ ] I earned the following degrees\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever serve in the military?  **[ ] Yes [ ] No**  **[ ] Conscientious Objector**

If so, which branch? **[ ] USA [ ] USN [ ] USMC [ ] USAF [ ] USCG**

If so, were you ever in combat? **[ ] Yes: Theatre\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]No**

If so, what kind of discharge did you receive? **[ ] Honorable [ ] General [ ] Other**

If so, do you have a service-connected disability? **[ ] Yes: \_\_\_\_\_\_\_\_\_\_\_% [ ] No**

**If SCD;** for**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you speak any languages *fluently* other than English? **[ ]Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] No**

**If** *yes*, what was your ***first* spoken language**(**s**)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the **jobs** have you’ve held, including being a homemaker or a stay-at-home parent:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work at the present time? **[ ] No [ ] Yes: [ ] Part time [ ] Full time**

What is your **current job** *title*, if “yes”: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If *yes*, are your cognitive or memory problems affecting your work, job, or schoolwork?

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

*If yes,* do you feel in danger of losing your job or being demoted? **[ ] Yes [ ] No**

Are you on disability? **[ ] Yes [ ] No** If yes, **[ ] medical** **[ ] psychiatric**

Are you applying for disability at this time? **[ ]** **Yes [ ] No [ ] Not sure**

Are you retired? **[ ] Yes [ ] No** If *yes*, retired in what year?\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 friends. [ ] I don’t have any friends I’m really close to.

[ ] I have a few close friends. [ ] I keep pretty much to myself.

Do you feel your social support system is solid and satisfactory enough for you?

**[ ] Yes [ ] No**

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

**Mood and Other Symptoms**

Please review this list very carefully and 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.

[ ] Do you have thoughts of suicide and sometimes feel afraid you might act on them? **[ ]Yes [ ] No**

[ ] Do you have thoughts of suicide but know you would never act on them. **[ ]Yes [ ] No**

[ ] I have felt or been suicidal at one or more times in the past.

[ ] There has been a time when I cut on myself or injured myself on purpose in some other way.

[ ] I have moments when I feel panicky all of a sudden.

[ ] I feel anxiety or nervousness nearly all the time that really doesn’t ever let up.

[ ] Sometimes I feel 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. **[ ] Yes [ ] No**

*If yes*, [ ] My mood swings are quick and sudden, or [ ] They are slow and gradual.

[ ] I have worried I might be “bipolar” or “manic depressive.”

[ ] I have been diagnosed with bipolar disorder (or manic depression or schizoaffective disorder).

[ ] 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.

[ ] Sometimes my speech becomes really fast and pressured for days at a time.

[ ] Sometimes I have trouble controlling my impulses, which could or does get me into

trouble. **If so:** My impulsivity occurs around **[ ] spending [ ] eating [ ] anger [ ] sex**

[ ] I sometimes have angry outbursts. **[ ] Yes [ ] No** *If ‘yes’:*

[ ] 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 I have strong thoughts or urges to harm or kill another person or an animal.

[ ] 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.” **[ ] Yes [ ] No [ ] Unsure**

If *yes:* During these episodes, is there [ ] staring without responding [ ] lip smacking behavior

[ ] picking at things for no reason [ ] other:

**Personal Habit Checklist**

**Caffeine:**

How much caffeine do you take in every day on average?

\_\_\_\_\_cups of coffee \_\_\_\_\_cups of tea \_\_\_\_\_\_caffeinated sodas/colas \_\_\_\_\_other

**Tobacco:**

Do you smoke?  **[ ] Yes [ ] No** How much a day if so? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years if yes?\_\_\_\_\_\_\_\_\_\_\_\_\_\_years

Did you smoke in the past but quit? **[ ] Yes [ ] No** When did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years before you quit, if yes?\_\_\_\_\_\_\_\_\_\_\_\_\_ Average per day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you chew tobacco? **[ ] Yes [ ] No** How much a week if so? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol:**

Do you drink alcoholic beverages?  **[ ] Yes [ ] No [ ] I used to, but I don’t anymore.**

Number of days per week I will have a drink \_\_\_\_\_\_\_\_\_

***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 [ ] 0

**If you drank** ***in the past but not now***, how many drinks did you used to 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 [ ] 0-2

**On your *heaviest* day of drinking** **in your whole life**, how many drinks did you have?

[ ] more than 24 [ ] 13-24 [ ] 9-12 [ ] 5-8 [ ] 3-4 [ ] 0-2

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 treatment program? **[ ] Yes [ ]No**

Have you ever had a period of time when you, *or others*, felt you drank too much on a regular basis, or

when you binge drank? **[ ] Yes [ ]No** If *yes*, during what years:\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a “black out” from drinking? **[ ] Yes [ ] No [ ] Unsure**

**Other**:

Which of the following substances have you used and/or do you currently use? Check both columns.

**Current/*Now* Previously/In the *past* Year *last* used?**

[ ] marijuana/pot/cannabis **[ ] 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 \_\_\_\_\_\_\_\_\_**

[ ] Opioids *not* prescribed by *your* doctor **[ ] yes [ ] no [ ] yes [ ] no \_\_\_\_\_\_\_\_\_**

Have you ever been ***treated*** *for* a drug use problem? [ ] yes [ ] no

Have ***you*** ever *worried* that 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

**Psychological Care History**

Have you ever been seen for detailed memory and cognitive testing or examination before?

**[ ] Yes: Approx. date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] No [ ] Unsure**

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

**If yes, from whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ degree:\_\_\_\_\_\_\_\_\_\_\_**

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

Psychologist (PhD, PsyD) **[ ] Yes [ ] No [ ] Unsure**

Psychiatrist (MD, DO) **[ ] Yes [ ] No [ ] Unsure**

Other psychotherapist (LCSW/MSW, LPC, MA, Psychiatric Nurse, etc.) or substance/alcohol use counselor or therapist (CAC, etc.). **[ ] Yes [ ] No**

**Or:** [ ] I have *never* been in therapy, or had any mental health care in the past of any sort.

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 ever been prescribed, *whether you are currently taking them or not*:**

Antidepressants Anti-anxiety medications Antipsychotic medications

Prozac/fluoxetine Zoloft/sertraline Celexa/citalopram Lexapro/escitalopram

Paxil/paroxetine Elavil/amitriptyline Pamelor/nortriptyline Haldol Seroquel

Abilify Risperdal Zyprexa Clozapine Pristiq Thorazine Mellaril

Luvox Xanax/alprazolam Valium/diazepam Ativan/lorazepam BuSpar Desipramine

Klonopin/clonazepam Ambien/zolpidem Lunesta Rozerem Sonata

Aricept/donepezil Exelon/rivastigmine Namenda/memantine Lithium Depakote/valproate

Cymbalta/duloxetine Imipramine/Pamelor Methadone Vivatrol Antabuse

NuPlazid Savella Fetzima Nardil Serzone Vrylar St. John’s Wort Kava

Restoril/temazepam Ritalin/Concerta Adderall Bupropion/Wellbutrin Trazodone

**Others not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Colorado Patient Rights Information /**

**HIPAA Acknowledgment**

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

**Dr. Schneiders’ credentials:**

Doctoral degree in Clinical Psychology, University of Colorado – Boulder 1985

Colorado License for the Independent Practice of Psychology #1152, 1987-2023

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: **In Colorado, a Licensed Psychologist must hold a doctorate degree in psychology, complete a one-year full time clinical internship, and have at least one year of post-doctoral clinical supervision.** **An ABPP Board Certified psychologist must in addition have several additional years in-depth post-graduate training and education in the specialty, and then pass national written and oral examinations in the specialty conducted by peers qualified 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 appropriate and necessary academic 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 and 1,000 hours of supervised experience. A CAC II must complete additional required training and 2,000 hours of supervised experience. A CAC III must have a bachelor’s degree in behavioral health and complete additional required training 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 but is *not* licensed or certified in in any of these fields of practice, and therefore *no degree, training or experience whatsoever is required to call oneself “Registered” in the State of Colorado.* A licensed Psychiatrist must hold a medical or osteopathic degree and have completed a one-year internship followed by a residency in psychiatry.

Any person who alleges that a psychologist or mental health professional has violated the licensing laws related to the maintenance of records of a patient eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the last date of professional clinical contact with a patient, whichever is later. *Patient records* *may not be retained after seven years following the date when the patient was last seen by Dr. Schneiders.*

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 a 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 professional relationship with *any* health care professional – psychologist, psychiatrist, physician, therapist, counselor, nurse, chiropractor or other – sexual intimacy is *never* appropriate, and should be *always* reported to the appropriate licensing, registration or certification board. *(Such activity is unethical and 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 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 and elder abuse as well as imminent danger to oneself or others to appropriate authorities. If such an extremely rare legal exception were to arise during patient care, where feasible, you would of course be informed.

*Billing Office Information* / Financial Policy: *For questions, please call Rhea at 720-587-7173. ABC Billing Service bills for us.* If we are on your insurance plan, we are pleased to bill them for your office visits. However, if you do not have insurance, payment for services is due at time they are rendered. Our office accepts cash, checks, Mastercard and Visa. Returned checks, and letters to you that require Certified Mail, will be subject to a $30.00 service charge. Charges *may* be made for telephone calls with the doctor over 10 minutes in length, and for additional medical reports, medical records, and in the case of not showing for appointments or 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 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 am attesting that the information provided by me to Dr. Schneiders and to staff from his office is true and correct to the best of my knowledge. I understand that I am responsible to pay for all services rendered including reasonable attorney’s fee and 100% costs of collection in the event of a default. I authorize Dr. Schneiders and/or his staff/billing service to furnish or obtain any and all information concerning his care and work with me with collection or other agencies affiliated with his practice, in the unlikely case of a defaulted claim.

I have read the preceding information, which has been offered/provided verbally, and I understand my rights as a patient or as the patient’s legally responsible party.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE HAD OPPORTUNITY TO READ THIS AGREEMENT WITH DR. SCHNEIDERS AND THAT YOU AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. ADDITIONAL HARD COPIES OF THE LATTER FORM AND PRACTICE INFORMATION MAY BE DOWNLOADED FROM THE PRACTICE WEBSITE [www.drjschneiders.com] AND ARE ALSO AVAILABLE DIRECTLY FROM DR. SCHNEIDERS AT HIS OFFICE.

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 ]**

**Jay L. Schneiders, PhD, ABPP**

Board Certified in Clinical Neuropsychology & in Clinical Health Psychology

**3601 S. Clarkson St., Suite 530, Englewood, CO 80113**

**Office: 720-587-7173 - Fax: 720-441-0484**

**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 clinical office staff, to release & exchange information about my medical/surgical/neuropsychological history, conditions, test results/data, examinations, and status. This may include information regarding abuse, drug, legal and alcohol history if any, mental health treatment and psychological/psychiatric conditions, and/or HIV/AIDS or Huntington’s disease status if known.

**This information may be released to and exchanged with the following:**

1. **Referring doctor**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **PCP**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Other doctors, psychotherapist, etc.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Hospital(s) or Facilities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Neuropsychological test data/raw data from previous examination(s) if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 [ ] until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 a 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 re-disclosure by any authorized recipient of my information and therefore no longer be protected by the HIPAA Privacy Rule.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient**  **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or: Signature of Patient’s Representative Date

*If the authorization is signed by a personal representative of the patient, a formal record of such*

*representative's authority legally to act for the patient must be provided.*

**Follow-up Feedback & Review Session**

Following your assessment (“testing”) session, it will take Dr. Schneiders a certain amount of time to analyze your results, to integrate them with your medical information and record, possibly to obtain further clinical records or reports, and to complete his own report, which is almost always very comprehensive. (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 **at least 3-4 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 in about 3-4 weeks following your appointment with him. [He also believes that your obtaining a 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] we ask that you phone the office as soon as possible following your examination to schedule a one-hour follow-up session for a review and discussion of your results. At that appointment – to which Dr. Schneiders invites you to bring family members or others importantly involved in your life and care if you wish – he will discuss your examination results, give you a copy of his report, and discuss treatment recommendations and options with you. Telehealth meetings are possible.

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**

**by checking one of the following below:**

**[ ] I will call the office and schedule a regular *in person* follow-up session to review**

**my test results and to obtain a copy of my final report from Dr. Schneiders.**

**[ ] I prefer to have a *Telehealth online video session* to review my findings.**

[ ] I prefer Dr. Schneiders just send me a copy of his report, and I will contact him if I have

any questions after receiving it. Please send my report to me:

**[ ] By regular mail to my home. [ ] Via my email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_**

Note: Email is *not* HIPAA secure/compliant, and requested

reports will be sent using security/password protection.

**[ ] By confidential and secure FAX: ( \_ \_ \_ ) - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_.**

This should *not* be a general office or public FAX or any FAX which others have access to.

[ ] I prefer Dr. Schneiders just send a copy of his report to my doctor(s). I do *not* wish to schedule a follow-up session or to receive a copy of his report.

**Your Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_202**