// JAY SCHNEIDERS, Ph.D., ABPP
Clinical Neuropsychology & Clinical Health Psychology
Office at **Swedish Medical Center: 701 E. Hampden Avenue Suite 535 , Englewood, CO 80113**

Patient's Name:____Date:____________________201__

Patient's address:____

City:___________________________________ State __________________ Zip___________________

Phone: : (H)______________________ (C) ________________________ (W) ______________________

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 [ ] Unemployed

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 reasonable attorneys' fees and 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 to furnish any/all information to my insurance carriers/Medicare/ Medicaid/My referring doctor(s) or clinician, concerning my illness, condition and treatments. 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

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 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 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 or epilepsy 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 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 your *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 best?

[ ] Yes [ ]No [ ] Not sure

Have you, or have other people you know, or has your family, noticed any 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 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
____Other:

____**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 and/or [ ] what people say to me than I used to
____Other:

____**Perceptual 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 problems with figuring out directions, and/or [ ] telling left and right
____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 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, 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 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.

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
___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/cannabis to help treat your medical issues and problems? [ ] Yes [ ] No

If yes, do you use [ ] *Edible* marijuana or [ ] *Smoking* marijuana or [ ] *Both*

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	
high cholesterol	___me	
diabetes	___me	
thyroid disease	___me	
cancer	___me	___family member
heart disease	___me	
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/TBI	___me	___family member
asthma	___me	
sleep apnea	___me	___family member
restless leg syndrome	___me	___family member
COPD	___me	
atrial fibrillation or flutter	___me	
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:

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 instead of listing here and 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 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 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.
[ ] 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 [ ] I walk in my sleep. [ ] I have nightmares. [ ] I have 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 often wake up some hours before I want to and can't get back to sleep.

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 about 3-6 hours a night.
____I use it throughout the entire night. ____I use it when I nap. ____I use it when I travel

___I use it once or twice a month. ___I use it about once or twice a week.
___I use it about 4-5 times a week. ___I use it every night.

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___________________________________

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 fluently 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?

____

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**

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 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."

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

Other:

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

	Current/*Now*	**Previously/in the *past***	**Year last used?**
[ ] 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

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Psychological Care History

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

Have you ever seen any of the following mental health professionals *at any time in the past,* for treatment, 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.).

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

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

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 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 Namenda Lithium Depakote valproate Cymbalta

___Other medicine not listed above that have been prescribed for mood, anxiety, thinking, sleep:

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
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 in-depth post-graduate training and education in the specialty, and then pass national written and oral examinations in the 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.

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.]

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, 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.

I have read the preceding information, which has been 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 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]

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) Neuropsychological test data/raw data from previous examination(s)_________________
   ____

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 formal record of such representative's authority legally to act for the patient must be provided.

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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 in about 3 weeks following your appointment with him.

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 you wish – 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.

[ ] Please have Sandy call me or ______________________________to schedule a follow-up.

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