Powers Ferry Psychological Associates, L.L.C.

The Offices of:
Gerald S. Drose, Ph.D.
Dina M. Zeckhausen, Ph.D.
Steven Perlow, Ph.D.
David M. Schwartz, Ph.D., ABPdN
Abby L. Friedman, Ph.D.
Kimberly Smiley, Psy.D.
Jennifer Spring, Ph.D.

And the Offices of:
Martin Fleet, Ph.D.
Susan Berel, Ph.D.
Elaine Eassa, Ph.D.
Keith Helmken, LCSW
Jennifer Swales, Ph.D.
Rachel Scheinfield, Ph.D.
Brian Smith, Psy.D.
Katherine Higgins, Ph.D.

OFFICE POLICIES

We would like to welcome you to the practice of David M. Schwartz, Ph.D., ABPdN. For your convenience we would like to provide the following helpful information. A copy is provided to you for future reference:

OFFICE HOURS

Dr. Schwartz is typically in the office from 8:30 a.m. through 5:00 p.m. However, office staff may not be available until 9:00 a.m. or past 5:00 p.m. After hours, please leave a message on Dr. Schwartz' Voicemail. His phone number is 770.973.7401.

CANCELLATION OF APPOINTMENTS

Your appointment time has been reserved for you. Unlike other doctors, psychologists do not schedule several patients at a time. When you miss or cancel your appointment at the last minute, this time cannot be offered to another patient. If you find that you cannot keep your scheduled appointment, please notify the office **at least 24 hours** prior to your appointment. Any scheduled appointments which are missed or are not cancelled within 24 hours will be billed to you. You will be responsible for the charges for missed appointments. We will do our best to see you at your scheduled time. If you come late for your appointment, you will be seen for the remainder of the time scheduled for you. It would not be fair to other clients to delay the start of their sessions.

PAYMENT AND INSURANCE

The fees for services provided by the independent psychologists affiliated with PFPA are among the lowest in Atlanta. Why? One reason is that we share expenses and overhead so that we keep our costs as low as possible. Another reason is that we share a belief that psychological services should be as widely available as possible. For this reason, all of us are on at least some insurance panels and have a policy of using a "sliding scale" to make services easier to afford. Each of the independent psychologists affiliated with PFPA has determined his or her fees, so feel free to discuss the fees with our business office representatives. Dr. Schwartz' patients should check with Tamara Onley at the Front Desk, by phone at 770.953.4744, ext. 26 or by email at tonley@powersferrypsychology.com.

Do you have Insurance? If you do have insurance with mental health benefits, then some or all of the fees for our services may be covered. This is by no means a sure thing, however. First, find out if Dr. Schwartz is "in network" and if so what your co-pay and deductible if any will be. If he is not in the network, it still might work out for you to use your insurance to see Dr. Schwartz. Often insurance companies will pay a percentage of the fees for "out-of-network" providers, but at a lower rate than an "in-network" provider. Check with your insurance company to find out what your deductible and percentage co-pay will be for out-of-network providers. Please be sure to view the patient agreement to pay for services that are not covered or limited by your insurance company.

PROFESSIONAL SERVICES AGREEMENT

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our time together. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. I am a part of Powers Ferry Psychological Associates, L.L.C. (PFPA). We are a group of professionals who share office and administrative resources; however, we practice independently of one another. This means that I, alone, am fully responsible for providing you or your child with clinical services.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office during regular business hours, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor. I will make every effort to return your call as soon as possible. If you are difficult to reach, please inform me of some times when you will be available. If you have an emergency and are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, call 911, or call the nearest emergency room and ask for the psychologist or psychiatrist on-call. If I will be unavailable for an extended time, I will always have a colleague available for you to contact in case of emergency.

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information to others about your treatment (or your child's treatment) if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this current agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record (which is called PHI in my notice of psychologists policies and practices to protect the privacy of your health information)
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and

communication with insurance companies. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist/patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services (DFCS). Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon him or her, other than by accidental means, or that he or she has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once I have filed such a report, I may be required to provide additional information.
- If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and /or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you or your child in two sets of professional records. One set constitutes your Clinical Record. It includes information about: your reasons for seeking my services, a description of the ways in which your or your child's problem impacts on your life, diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself, your child, or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person (or if information is supplied to me confidentially by others), you or your legal representative may examine and /or receive a copy of your or your child's Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I require that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you or your child with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your or your child's treatment. They also contain particularly sensitive information that you or your child may reveal to me that is not required to be included in your Clinical Record and information supplied to me confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you. They also cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your or your child's record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement; the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy and treatment is often crucial to successful progress, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. The results of psychological testing of a minor typically will be shared with parents or guardians. They may also be shared with other entities such as schools or physicians with parental consent.

FINANCIAL AGREEMENTS

PROFESSIONAL FEES

The Diagnostic Interview is billed at $200 per hour. The fee for an evaluation is $2500. This fee includes the Assessment and Report Writing, as well as the Results/Feedback session up to a total of 10 hours. If the Assessment takes more than 9 total hours, additional time will be billed at the cost of $200 per hour.

In addition to scheduled appointments, this office charges $200 per hour for other professional services you may need, though we will break down the hourly cost for periods of less than one hour. Other services that are billed include school meetings, employer meetings, family consultations, preparation of records or treatment summaries, filling out forms, and other services that are requested.

You will be charged $100 if you do not provide 24 hours-notice of a cancelled evaluation appointment (unless, in either situation, we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled appointments. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation for depositions, court testimony, and transportation costs, even if I am called to testify by another party. The fee for testifying in court is $250 per hour, "door-to-door." You will be charged for waiting time.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time of service, unless you have consulted with our front office to make other arrangements. **The Diagnostic Interview is due and payable on the day of the Diagnostic Interview. The cost of the evaluation is split into two parts, with one-half due on the first day of testing and the other half due before the written report is released.** ***No written evaluation reports will be provided until your outstanding balance is paid or approval is given by our business office.*** Verbal feedback will be provided after the evaluation. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

We are a Fee-for-Service practice. Your balance is due and payable as outlined above. Our office will be glad to help you submit insurance forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. ***However you, not your insurance company, are responsible for full payment of the charges.*** It is very important to determine exactly what mental health and/or medical services your insurance policy covers prior to your appointment or evaluation. You should also be aware that your contract with your health insurance company may require that we provide it with information relevant to the services that were provided to you. We may be required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. Although all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands.

We will assist you in submitting the appropriate bills to your insurance company and try to remedy any denial or payment problem related to billing. If after these attempts, the insurance company still refuses to reimburse you, there is very little we can do after that.

If you or your child is covered by a secondary insurance plan, we will be happy to provide you with appropriate billing forms and Explanation of Benefit (EOB) forms from your primary plan. You are responsible for payment of the portion of services not covered by your primary plan and you need to seek reimbursement from the secondary plan for yourself.

Typical insurance plans such as HMO's and PPO's are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more treatment after a certain number of sessions. We will assist you in obtaining authorization for further sessions. While much can be accomplished in short-term treatment, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your treatment.

A copy of your evaluation report will be sent, with your permission, to your referring doctor(s). There will be no charge for any additional copies.

If you have any questions regarding office policy, please do not hesitate to contact us. We will be happy to work with you in any way that we can.

Thank you for choosing our practice and we look forward to seeing you.

Please sign the next page to indicate that you have read and understand the office policies and have received a copy for your reference.

SIGNATURE PAGE FOR OFFICE POLICIES

By signing this Agreement, I acknowledge that I have been made aware of David M. Schwartz', Ph.D., ABPdN Office Policies and agree to abide by them. I also agree that his office can provide any requested medical, psychological and/or neuropsychological information to my carrier, or its agents, if required for determination or payment of benefits. I am also assigning benefits to David M. Schwartz, Ph.D. for any clinical services that are provided.

I am eligible for coverage under more than one health insurance policy (please circle): Yes No

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client signature_____ **Date**_____

Guarantor (if different)_____ **Date**_____

Witness_____ **Date**_____

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NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
    - Treatment refers to when I provide, coordinate or manage your health care, and provide other services related to your health care. An example of treatment is when I consult with another health care provider, such as your family physician or another psychologist.
    - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care, or to determine eligibility or coverage.
    - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities; business-related activities, such as audits and administrative services; and case management and care coordination activities.
    - "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. Psychotherapy Notes are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will make this information available either by mail or by request for a review of this information.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Steven Perlow, Ph.D., Privacy Officer, at 770-953-4744 x14. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on April 14, 2003.

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NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

I, the undersigned, acknowledge that I have received, read and understand the "*Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information*" form from Powers Ferry Psychological Associates (Version 04/14/2003).

This policy became effective April 14, 2003 as required by law under HIPAA (Health Insurance Portability and Accountability Act).

Signature: _____ Date: _____

or

Signature: _____ Date: _____
(Parent, Guardian, or Legal Representative)

If applicable, secondary party/ parties , 18 years of age or older, participating in treatment:

Signature of Secondary Party/Parties: _____ Date: _____

Name(s) of Secondary Party/Parties (Please Print): _____
and Relationship to Patient
_____

Signature Treating Psychologist: _____ Date: _____

Name of Treating Psychologist: _____

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PAYMENT FOR SERVICES AGREEMENT

Provider/Supplier Notice to Beneficiary Regarding Service(s) That May Be Denied Payment by Your Insurance Carrier as "Not Reasonable and Necessary"

Notice to Beneficiary:

Your insurance company: _____ may only pay for services that ***it*** determines to be ***"reasonable and necessary"*** under their contract with you/the enrolled individual and Dr. Schwartz. If your insurance company determines that a particular service, is *"not reasonable and necessary"* or viewed as a *"not-covered service"* or the evaluation leads to diagnosis that is not covered, your insurance company may deny payment for that service.

You, alone, are responsible for payment of services and the insurance company may or may not reimburse you.

By signing this Agreement, I acknowledge that I have been made aware of Dr. Schwartz' Payment for Services Agreement and agree to abide by it. I also agree that his office can provide any requested medical, psychological and/or neuropsychological information to my carrier, or its agents, if required for determination or payment of benefits.

I am eligible for coverage under more than one health insurance policy (please circle): Yes No

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client signature_____ **Date**_____

Guarantor (if different)_____ **Date**_____

Witness_____ **Date**_____

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ADULT NEUROPSYCHOLOGICAL HISTORY

Name: _____ Date: _____

Address (home): _____ Phone: _____

Email Address: _____

Age: _____ Date of Birth: _____ Education: _____

College: ☐ Yes ☐ No If yes, where? When? Major? _____

Did you Graduate College: ☐ Yes ☐ No Highest Degree Completed: _____

Race: _____ Eyes: _____ Hair: _____ Height: _____ Weight: _____

Reason for Referral: _____

_____

What is your objective for this evaluation: _____

_____

Occupation: _____

Hobbies and Interests: _____

Marital Status: _____ Spouse's/Significant Other's Name: _____

Children: _____

Father - Age: _____ Occupation: _____ Education: _____

Mother - Age: _____ Occupation: _____ Education: _____

Birth Order – Brothers: _____ Sisters: _____

MEDICAL/HEALTH HISTORY

Physician: _____ Phone: _____

Address: _____

Date of last physical exam: _____

Vision problem? ☐ Yes ☐ No Date of last vision exam: _____

Hearing problem? ☐ Yes ☐ No Date of last hearing exam: _____

Appetite concerns? ☐ Normal ☐ Picky ☐ Eat too much ☐ Weight loss/gain

Oral-motor concerns? ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Do you have problems falling asleep? ☐ Yes ☐ No If yes, how long does it take you? _____

Do you wake up in the middle of the night? ☐ Yes ☐ No If yes, how many times per night? _____

If yes, why? _____ How long does it take for you to go back to sleep? _____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for Discontinuing

Surgeries – (Age/Reason): _____

_____

Hospitalizations – (Age/Reason): _____

_____

Major accidents or injuries – (Age/Details): _____

_____

_____

Have you ever been unconscious? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you have current problems with:

	Yes	No	?		Yes	No	?
Ears (specify) **R L Both**				**Appetite, digestion, stomach problems**			
Poor hearing				Frequent stomach aches			
Chronic earaches/infections				Poor eating habits			
Draining ears				Frequent vomiting			
				Soiling or daytime accidents			
Eyes (specify) **R L Both**				Constipation			
Poor vision				Problems with weight			
Crossed eyes							
Wears glasses				**Hematology (Blood)**			
				Anemia			
Endocrine				Excessive bleeding or bruising			
Thyroid problems				Leukemia			
Diabetes				Sickle cell disease			
Hypo/Hyperpituitarism				Other:			
Growth problems							
Other:							
				Excretory System			
				Urine and/or bladder problems			
Nervous System				Bedwetting			
Frequent and/or severe headaches				Daytime wetting and/or accidents			
Seizures or convulsions				Urinary tract infections			
Tremors or twitches							
Coordination problems				**Respiratory System**			
Balance problems				Wheezing and/or asthma			
Frequent dizziness				Other:			
Other:							
Cancer				**HIV/AIDS**			

Have you had any of the following?

Ear Tubes	☐ Yes	☐ No	If yes, number of tube placements _____
Encephalitis	☐ Yes	☐ No	
Meningitis	☐ Yes	☐ No	
Poisoning or drug intoxication	☐ Yes	☐ No	
Coma	☐ Yes	☐ No	If yes, what was the cause? _____
Staring spells	☐ Yes	☐ No	
Immune system disorders	☐ Yes	☐ No	
Other significant illness	☐ Yes	☐ No	

If yes to any of the above, please provide additional details: _____

_____

Have you had any of the following tests or treatments?

	Yes	No	Date (month/year)	Where	Results
Neurologic Evaluation					☐ Normal ☐ Abnormal ☐ Don't know
CT Scan of head					☐ Normal ☐ Abnormal ☐ Don't know
MRI of head					☐ Normal ☐ Abnormal ☐ Don't know
EEG					☐ Normal ☐ Abnormal ☐ Don't know
Genetic Testing					☐ Normal ☐ Abnormal ☐ Don't know
Chemotherapy					☐ Normal ☐ Abnormal ☐ Don't know
Radiation Therapy					☐ Normal ☐ Abnormal ☐ Don't know
Other					☐ Normal ☐ Abnormal ☐ Don't know
					☐ Normal ☐ Abnormal ☐ Don't know

Have you ever had: ☐ Traumatic Brain Injury ☐ CVA/Stroke ☐Aneurysm ☐ Heart Attack

If yes, please provide the details for each:

Date: _____ Loss of Consciousness: ☐ Yes ☐ No If yes, how long? _____

Details: _____

_____

_____

_____

_____

DEVELOPMENT

Did your mother receive prenatal care during the pregnancy? ☐ Yes ☐ No Starting in which month? _____

Number of the following your mother has had (including you):
Pregnancies _____ Miscarriages _____ Premature Births _____

Did your mother have any of the following during or immediately before/after the pregnancy (check all that apply)

☐ Emotional stress
☐ Toxemia
☐ Excessive swelling (edema)
☐ Flu
☐ Vaginal bleeding-when?_____
☐ Epilepsy/seizure
☐ Other (Rh incompatibility, etc.)
☐ Infections (cold, flu)
☐ Anemia
☐ Measles/German measles
☐ High blood pressure
☐ Strep throat
☐ X-ray studies
☐ Diabetes
☐ Preterm labor/bedrest
☐ Abnormal weight gain
☐ Excessive vomiting
☐ Kidney disease
☐ Threatened miscarriage
☐ Fever
☐ Other virus
☐ Maternal injury. Describe: _____
☐ Operation/hospitalization during pregnancy. Reason: _____

Were any of the following used during your Mother's pregnancy with you? (check all that apply)

☐ Prescribed medications. (Please specify): _____ For: _____
☐ Tobacco
☐ Amphetamines
☐ Cocaine
☐ Marijuana
☐ Heroin
☐ Alcohol
☐ Methamphetamines
☐ Methadone
☐ Other (specify) _____

BIRTH HISTORY

Age of mother at birth? _____ Age of father at birth? _____

Were you born full term? ☐ Yes ☐ No Number weeks gestation _____

Birth weight: _____lbs. _____oz. APGARS (if remembered) _____ at 1 min _____ at 5 min.

Type of Labor Onset: ☐ Induced ☐ Spontaneous

Type of Birth: ☐ Vaginal ☐C/Section (Planned? ☐ Yes ☐ No Emergency? ☐ Yes ☐No)
☐ Vaginal Birth after C/Section (VBAC) ☐ With Instruments (forceps)

Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local ☐ None

Baby's Presentation: ☐ Breech ☐ Head ☐ Transverse (sideways)

Please check the following problems that may have occurred during labor:

Yes	No		Yes	No	
☐	☐	Toxemia/eclampsia	☐	☐	Fetal distress
☐	☐	Maternal fever	☐	☐	Medications used (please specify):

Length of active labor: _____hours. Describe any complications during delivery: _____

_____

POST-DELIVERY PERIOD

Check which of the following problems may have occurred after your birth, if known:

Yes	No		Yes	No	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck (# of times ____)	☐	☐	Poor feeding
☐	☐	Knot in cord	☐	☐	Were you nursed? How long? _____
☐	☐	Seizures	☐	☐	Required a blood transfusion
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Vomiting / reflux
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Floppy muscle tone
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Fever
☐	☐	Incubator care	☐	☐	Other _____

Have you been given a specific diagnosis?

☐ Learning Disability
☐ Language disorder
☐ Attention Deficit Disorder (ADHD)
☐ Oppositional Defiant Disorder (ODD)
☐ Autism/ Asperger's/ PDD
☐ Other
☐ Intellectual Disability
☐ Developmental Delay
☐ Epilepsy
☐ Tourette's Disorder
☐ Fragile X
☐ Genetic Disorder
☐ Anxiety Disorder
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia

LANGUAGE

First Language: _____

History of Speaking/Language Difficulties: ☐ Yes ☐ No If yes, please explain: _____

_____

MILITARY SERVICE

Branch of Military and Dates of Service: _____

Highest Rank: _____

Jobs Held: _____

Combat History: _____

Conduct Problems: ☐ Yes ☐ No If yes, please explain: _____

Rank at Discharge: _____

Type of Discharge: _____

FAMILY MEDICAL HISTORY

Have any of your family members had the following problems/disorders? Please specify the family member's relationship to you and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

	Family Member(s) Relation		Family Member(s) Relation
☐ Birth Defect		☐ Reading Problem(s)	
☐ Genetic Disorder		☐ Other Learning Disability	
☐ Cerebral Palsy		☐ Speech/Language Delay	
☐ Migraines		☐ Intellectual Disability	
☐ Multiple Sclerosis		☐ Autism/Asperger's	
☐ Physical Handicap		☐ ADHD	
☐ Huntington's Chorea		☐ Oppositional Behaviors	
☐ Muscular Dystrophy		☐ Antisocial Behavior	
☐ Sickle Cell Anemia		☐ Aggression	
☐ Seizures/Epilepsy		☐ Tics/Tourette's Disorder	
☐ Cancer		☐ Anxiety/Nervousness	
☐ Diabetes		☐ Obsessive-Compulsive	
☐ Heart Disease		☐ Depression	
☐ Alcohol Abuse		☐ Bipolar Disorder	
☐ Drug Abuse		☐ Schizophrenia	
☐ Physical Abuse		☐ Other (specify)	
☐ Sexual Abuse		☐	

FAMILY

Father

Name: _____ Birthday/Current age: _____ Education: _____

Occupation: _____

Marital History: _____ Personality: _____

Relationship with patient: _____

Health status/problems: _____

Psychiatric History: _____

Substance Abuse: _____

Legal Difficulties: _____

Mother

Name: _____ Birthday/Current age: _____ Education: _____

Occupation: _____

Marital History: _____ Personality: _____

Relationship with patient: _____

Health status/problems: _____

Psychiatric History: _____

Substance Abuse: _____

Legal Difficulties: _____

Sibling

Name: _____ Birthday/Current age: _____ Education: _____

Occupation: _____

Marital History: _____ Personality: _____

Relationship with patient: _____

Health status/problems: _____

Psychiatric History: _____

Substance Abuse: _____

Legal Difficulties: _____

Sibling

Name: ______________________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: __________________________ Personality: ______________________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

Sibling

Name: ______________________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: __________________________ Personality: ______________________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

Sibling

Name: ______________________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: __________________________ Personality: ______________________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

SEXUAL

Puberty (what age?): ______ Changes in sexual behavior?: ☐ Yes ☐No If yes, please explain: __________

____Sexual Problems: ☐ Yes ☐ No

If yes, please explain: ____

MARITAL

Marital Status: _____ Name/Age of Spouse/Significant Other: _____

Occupation of Spouse: _____

Marital Problems: ☐ Yes ☐ No If yes, please explain: _____

Previous Marriage(s): _____

SOCIAL/RECREATIONAL

Social Contact Level: _____

Social Activities: _____

Hobbies: _____

Amount of Social/Leisure Time/Week: _____

LEGAL

Problems as a juvenile: ☐ Yes ☐ No If yes, please explain: _____

_____

Misdemeanor Offenses: ☐ Yes ☐ No If yes, please explain: _____

_____

Felony Arrests/Offenses: ☐ Yes ☐No If yes, please explain: _____

_____

Convictions: ☐ Yes ☐No If yes, please explain: _____

_____

Time served: ☐ Yes ☐No If yes, please explain: _____

_____

Lawsuits/Civil Litigation ☐ Yes ☐No If yes, please explain: _____

_____

SYMPTOM SURVEY

Below is a list of items and behaviors that commonly describe people. Please check all behaviors that you currently exhibit or have exhibited in the past. Please add any helpful comments next to the items.

PROBLEM SOLVING

Current	Past	
☐	☐	Difficulty figuring out how to do new things
☐	☐	Difficulty making decisions
☐	☐	Difficulty planning ahead
☐	☐	Difficulty solving problems
☐	☐	Disorganized in your approach to problems
☐	☐	Difficulty understanding explanations
☐	☐	Difficulty doing things in the right order (sequencing)
☐	☐	Difficulty verbally describing the steps involved in doing something
☐	☐	Difficulty completing an activity in a reasonable period of time
☐	☐	Difficulty changing a plan or activity when necessary
☐	☐	Is slow to learn new things
☐	☐	Difficulty switching from one activity to another activity
☐	☐	Easily frustrated
☐	☐	Other problem solving difficulties:

SPEECH, LANGUAGE, AND MATH SKILLS

Current	Past	
☐	☐	Difficulty speaking clearly
☐	☐	Difficulty finding the right word to say
☐	☐	Not talking
☐	☐	Rambles on and on without saying much
☐	☐	Jumps from topic to topic
☐	☐	Odd or unusual language or vocal sounds
☐	☐	Difficulty understanding what others are saying
☐	☐	Difficulty understanding what you are reading
☐	☐	Difficulty writing letters or words
☐	☐	Difficulty reading letters or words
☐	☐	Difficulty with math
☐	☐	Other speech, language, or math problems:

SPATIAL SKILLS

Current	Past	
☐	☐	Confusion telling right from left
☐	☐	Has difficulty with puzzles, or assembling items from diagrams
☐	☐	Problems drawing or copying
☐	☐	Don't know your colors
☐	☐	Difficulty dressing (not due to physical difficulty)
☐	☐	Problems finding your way around places you have been to before
☐	☐	Difficulty recognizing objects
☐	☐	Seem unable to recognize facial or body expressions of disapproval or emotions
☐	☐	Gets lost easily
☐	☐	Other spatial problems:

AWARENESS AND CONCENTRATION

Current	Past	
☐	☐	Easily distracted by: Sounds ☐ Sights ☐ Physical sensations ☐
☐	☐	Mind appears to go blank at times
☐	☐	Loses train of thought
☐	☐	Difficulty concentrating on what others say, but can sit in front of a TV for long periods
☐	☐	Attention starts out OK but can't keep it up
☐	☐	Other attention or concentration problems:

MEMORY

Current	Past	
☐	☐	Forget where you leave things
☐	☐	Forget things that happened recently (e.g., last meal)
☐	☐	Forget things that happened days/weeks ago
☐	☐	Forget what you are supposed to be doing
☐	☐	Forget names more than most people do
☐	☐	Forget work assignments
☐	☐	Forget instructions
☐	☐	Other memory problems:
☐	☐	
☐	☐	

PHYSICAL

Current	Past	
☐	☐	Frequently complain of headaches or nausea How often?
☐	☐	Have dizzy spells How often?
☐	☐	Have pains in joints Where?
☐	☐	Excessive tiredness When?
☐	☐	Frequent urination or drinking
☐	☐	Other physical problems:

MOTOR AND COORDINATION

Current	Past	
☐	☐	Fine motor control problems (using a pen/pencil) **R side L side Both**
☐	☐	Clumsy **R side L side Both**
☐	☐	Weakness **R side L side Both**
☐	☐	Tremor **R side L side Both**
☐	☐	Muscles are tight or spastic **R side L side Both**
☐	☐	Odd movements (posturing, peculiar hand movements, etc.) **R side L side Both**
☐	☐	Drop things more than most people **R side L side Both**
☐	☐	Have an unusual walk
☐	☐	Balance problems
☐	☐	Other motor or coordination problems:

SENSORY

Current	Past	
☐	☐	Needs to squint or move closer to page to read **R side L side Both**
☐	☐	Problems seeing objects **R side L side Both**
☐	☐	Loss of feeling **R side L side Both**
☐	☐	Problems hearing sounds **R side L side Both**
☐	☐	Difficulty telling hot from cold **R side L side Both**
☐	☐	Difficulty smelling odors **R side L side Both**
☐	☐	Difficulty tasting food **R side L side Both**
☐	☐	Overly sensitive to: ☐Touch ☐ Light ☐ Noise
☐	☐	Other sensory problems:
☐	☐	

BEHAVIOR

Current	Past		Current	Past	
☐	☐	Aggressive	☐	☐	Nervous
☐	☐	Attached to things, not people	☐	☐	Nightmares, night terrors, sleepwalks
☐	☐	Toileting Accidents (day / night)	☐	☐	Quiet
☐	☐	Unusual behavior	☐	☐	Resists change
☐	☐	Bowel movements in underwear	☐	☐	Risk-taking
☐	☐	Dependent	☐	☐	Self-mutilates
☐	☐	Depressed	☐	☐	Self-stimulates
☐	☐	Eating habits are poor	☐	☐	Shy and withdrawn
☐	☐	Emotional	☐	☐	Sleeping habits are poor
☐	☐	Fearful	☐	☐	Swears a lot
☐	☐	Immature	☐	☐	Unmotivated

Do you currently (within the past 6 months) display any of the following behaviors frequently?

These behaviors should occur more frequently than in others the same age

- ☐ Fainting, falling
- ☐ Clumsiness
- ☐ Shy, timid
- ☐ Social Isolation
- ☐ Lack of confidence
- ☐ Low self-esteem
- ☐ Crying episodes
- ☐ Unhappiness
- ☐ Concern with weight
- ☐ Sleep problem
- ☐ Anxiety
- ☐ Unusual fears
- ☐ Avoidance
- ☐ Laziness
- ☐ Other:

- ☐ Poor concentration
- ☐ Short attention span
- ☐ Distractibility
- ☐ Low frustration tolerance
- ☐ Impulsivity
- ☐ Hyperactivity
- ☐ Attention seeking
- ☐ Irritability
- ☐ Temper tantrums
- ☐ Oppositional behavior
- ☐ Noncompliance
- ☐ Defiance
- ☐ Lying

- ☐ Obsessive-compulsive behaviors
- ☐ Stereotyped/repetitive behaviors
- ☐ Memory loss
- ☐ Physical aggression
- ☐ Stealing
- ☐ Use of profanity
- ☐ Skipping work
- ☐ Fire setting
- ☐ Destructiveness
- ☐ Cruelty to animals
- ☐ Gang Involvement
- ☐ Cigarette use
- ☐ Alcohol / Substance use

Overall your symptoms have developed: ☐ Slowly ☐ Quickly

The symptoms occur: ☐ Occasionally ☐ Often

Over the past six (6) months, the symptoms have: ☐ stayed about the same ☐ worsened

SERVICES/INTERVENTIONS PREVIOUSLY SOUGHT

- ☐ Medical Evaluation
- ☐ Neuropsychological Evaluation
- ☐ Occupational Evaluation/Treatment
- ☐ Other:

- ☐ Neurological Exam/Evaluation
- ☐ Speech/Language Evaluation/Therapy
- ☐ Physical Therapy Evaluation/Treatment

- ☐ Psychiatric Exam/Evaluation
- ☐ Psychological Evaluation/Treatment
- ☐ Medication

Have you had any of the following forms of psychological treatment? If so, how long did it last?

Individual psychotherapy	☐ Yes	☐ No	Duration of therapy?
Group psychotherapy	☐ Yes	☐ No	Duration of therapy?
Parenting classes	☐ Yes	☐ No	Duration of classes?
Residential treatment	☐ Yes	☐ No	Duration of placement?

PSYCHIATRIC HISTORY

Emotional/Psychological problems: _____

_____

Psychiatric diagnoses (type/age): _____

_____

Treatment history (type/age): _____

_____

Medications: _____

_____

Therapies: _____

_____

Hospitalizations: _____

_____

Suicidal Ideations/Gestures: _____

_____

ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

Powers Ferry Psychological Associates, L.L.C.

The Offices of:
Gerald S. Drose, Ph.D.
Dina M. Zeckhausen, Ph.D.
Steven Perlow, Ph.D.
David M. Schwartz, Ph.D., ABPdN
Abby L. Friedman, Ph.D.
Kimberly Smiley, Psy.D.
Jennifer Spring, Ph.D.

And the Offices of:
Martin Fleet, Ph.D.
Susan Berel, Ph.D.
Elaine Eassa, Ph.D.
Keith Helmken, LCSW
Jennifer Swales, Ph.D.
Rachel Scheinfield, Ph.D.
Brian Smith, Psy.D.
Katherine Higgins, Ph.D.

Consent for Evaluation

I, _____, hereby authorize and request that David M. Schwartz, Ph.D. evaluate me, based on his professional opinion.

I understand that I have no obligation whatsoever to grant this permission and that I may revoke this consent at any time by informing David M. Schwartz, Ph.D. in writing. I further understand that this authorization is valid until I revoke this privilege in writing.

I also acknowledge, with my signature, that David M. Schwartz, Ph.D. has explained to me the nature, purpose, and basic procedures of this evaluation.

In consideration of this consent, I hereby release David M. Schwartz, Ph.D. from any legal liability resulting from this evaluation.

Signature: _____ Date: _____

or

Signature: _____ Date: _____
(Parent, Guardian, or Legal Representative)

Powers Ferry Psychological Associates, L.L.C.

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Katherine Higgins, Ph.D.

Release of Information

I hereby authorize _____

to: ☐ release ☐ receive ☐ exchange

any and all information concerning _____ (Name of Patient, DOB)

☐ to ☐ from ☐ with **David M. Schwartz, Ph.D., ABPdN**

I understand that such disclosure will be made for the following purposes:

☐ Neurosychological Evaluation ☐ Psychiatric Evaluation ☐ Child Custody/Visitation
☐ Diagnosis ☐ Social History ☐ Competency to stand trial
☐ Medical Treatment ☐ Treatment Progress ☐ Treatment Summary
☐ Academic Placement ☐ Other _____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and if not earlier revoked, it shall terminate 365 days from date of signature without revocation.

I understand that disclosures may not be subject to confidentiality if Dr. Schwartz becomes aware of any suicidal or homicidal thoughts or plans, or any form of abuse or neglect.

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

I have read or had read to me, the above information and understand the contents.

_____ I authorize this information to be faxed or emailed to the party indicated above and understand
Initial the limits of confidentiality which doing so creates.

Signature: _____ Date: _____

or

Signature: _____ Date: _____
(Parent, Guardian, or Legal Representative)