

PSYCHOLOGY CENTER

of IDAHO FALLS

3729 Woodking Dr. Suite 1 • Idaho Falls, ID 83404 • Ph: 208.522.3404

Testing Registration

Name _____ Male _____ Female _____

Mailing Address _____ Married? Yes _____ No _____

Spouse's Name: _____

Phone: Home _____ Work/Cell _____

Ok to leave voice messages? Yes _____ No _____ Ok to text for reminders/info? Yes _____ No _____

Age: _____ Date of Birth: _____ Birthplace: _____

Email Address: _____

Referral Source: _____ Social Security #: _____

Current Concerns: _____

Current Medications: _____

Employer/School Information:

Occupation: _____

Employer: _____

Highest Grade Completed: _____ Current Grade (if applicable): _____

Current School (if a student): _____

Primary Care Physician: _____

Insurance:

Insurance Company: _____ Policy #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Address: _____

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TESTING CONSENT FORM

This form will provide information about my services and about your rights and responsibilities as a clinical patient. Please be sure to discuss any questions with the provider. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment, and abide by any role restrictions set forth in this informed consent.

TESTING:

Through the use of a variety of standard psychological and/or neuropsychological tests, the provider will attempt to answer the questions that have brought you here for this follow-up assessment. These questions generally concern obtaining updated information about psychological or neuropsychological functioning. Throughout the assessment you have the right to inquire about the nature or purpose of all procedures. You have the right to withdraw from the testing session at any time. You also have the right to know the test results, interpretations, and recommendations. The assessment process generally involves an informational intake interview followed by the administration of psychological tests. Once testing is completed and the data have been analyzed, a report will be issued and you will have the opportunity to ask questions and/or discuss the results with the provider.

CONFIDENTIALITY & PRODUCTION OF RECORDS:

The information obtained in this evaluation is confidential and will not be released to any person or organization without your written consent. The only exceptions to this policy are rare situations in which we are required by law to release information without your permission. These are 1) if there is evidence of physical and/or sexual abuse of children, or abuse to the elderly; 2) if it is judged that you are in danger of harming yourself or another individual; or 3) if your records or the provider's testimony are sought by subpoena. We will attempt to notify you before any action is taken and would limit disclosure of confidential information to the minimum required to comply with the law. Raw data (e.g. test protocols and/or other copyrighted or trademarked materials) will not be provided, unless the provider has been court-ordered to provide these items, and with distribution/disposal stipulations in place.

FEE AND PAYMENT POLICY:

The standard fee for Psychological Testing is \$175/hour and \$195/hour for Neuropsychological Testing. The Clinical Interview is billed at \$250. Submission to private insurance companies for reimbursement may be done, upon request. All co-pays are due at the time of service. Any portion of the bill that goes unpaid by the insurance carrier will be billed to the patient. It is the responsibility of the patient/guardian to inquire about and obtain pre-authorization (when required by his/her policy) and to be informed about any other specific insurance coverage/conditions that may or may not apply.

MISSED APPOINTMENTS:

For the courtesy of other patients that are waiting for appointment times, Cancellations must be made at least 24 hours prior to the scheduled appointment. Late cancellations (less than 24 hours notice) and "No-Shows" will be assessed a \$50 fee to be paid prior to scheduling their next appointment. Two Late cancellations or "No-Shows" will result in the client no longer being eligible for services at PCIF.

AGREEMENT:

I have read the above material, and I fully understand my rights and obligations as a client. **I understand that the interpretation of assessment findings are based on test results and professional judgments, and that I may obtain a second opinion at my discretion.** I freely agree to this assessment. I understand that I am responsible for charges that are not covered under my insurance policy and/or charges that are incurred due to failure to inquire about or obtain pre-authorization, if applicable.

Name of Client

Date

Signature

Date

(Patient or parent/legal guardian)

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Acknowledgement of Notice of Privacy Practices:

The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of who we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have had the opportunity to receive a copy of the Notice of Privacy Practices.

Signature: _____ (of patient or legal representative)

Date: _____

Capacity of Legal Representative (if applicable)*: _____

Consent

I give, Psychology Center of Idaho Falls, my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the Psychology Center of Idaho Falls, Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that the Psychology Center of Idaho Falls has the right to change its privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____

Date: _____

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Consent to Release Medical Information

Name of Client: _____ Date of Birth: _____

Information to Be Released: Communication with Provider
 Psychological Testing Report
 Other: _____

Designated office from which information is being requested:

Name: Psychology Center of Idaho Falls
Address: 3729 Woodking Dr. Suite 1
Idaho Falls, ID 83404
Phone: (208) 522-3404 Fax: (208) 524-1093

Name of Physician, Health Care Provider, Hospital and/or Other Designated Person/Office authorized to communicate and/or receive records specified above:

Name: _____

Address: _____

Phone: _____

Fax: _____

Purpose of Disclosure: _____

Statement of Consent:

The undersigned does hereby authorize and consent to the disclosure of any and all information, records, documents, reports, clinical abstracts, histories and charts, of every kind and description, relating to the condition, care, confinement and treatment of the above-named patient, by the above-named individual or entity or their representative, to the above-named physician or physicians, health care provider, hospital, and/or other designated person(s), and does consent to the inspection and duplication of the indicated records by the same.

Treatment is not conditional upon signing this release and the client has the right to revoke this release at any time.

The undersigned further agrees to waive any and all privileges granted under the provision of law which may either directly or indirectly pertain to this disclosure as hereby authorized. This release will remain valid for 6 months from the date of signature.

Signature _____

Date _____

Office use only:

Reason unable to obtain signature: _____
