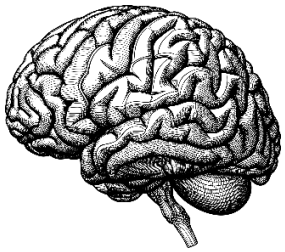

GKB Neuropsychology

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SECTION 1: Patient Demographic & Contact Information

Patient Name: _____ **Phone:** _____

DOB: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female ☐ Other

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN: _____ **Driver's License:** _____ **State:** _____

Phone: _____ **Email:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Employer: _____ **Work Phone:** _____

Referring Provider / Source: _____

Reason for Referral: _____

_____

SECTION 2: Emergency Contact Information

Emergency Contact 1: _____ **Phone:** _____ **Relation:** _____

SECTION 3: Insurance Information

Primary Insurance: _____

Policy Holder Name: _____ **Relationship to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SSN:** _____

Member ID #: _____ **Group #** _____

Insurance Phone #: _____

Secondary Insurance (*if applicable*): _____

Member ID #: _____ **Group #** _____

Insurance Phone #: _____

SECTION 4: Basic Medical Information

Primary Care Provider: _____ **Phone:** _____

Current Medications: *(Please list all medications and dosages)*

_____

_____

_____

_____

_____

_____

_____

Major Medical Conditions: _____

_____

_____

_____

Allergies: _____

History of Head Injury/Concussion: ☐ No ☐ Yes Details: _____

Vision/Hearing Problems: ☐ No ☐ Yes Details: _____

Do you wear hearing aids: ☐ No ☐ Yes **Do you wear glasses/readers:** ☐ No ☐ Yes

Are you currently experiencing any medical emergency or urgent symptoms? ☐ No ☐ Yes Details: _____

_____

SECTION 5: Legal Authority & Consent

For patients 18 and older: Patient may consent for themselves

For patients under 18: Parent/Guardian Name: _____

- **Relationship:** _____ **Legal Authority:** ☐ Yes ☐ No

For patients with guardianship/conservatorship: Guardian Name: _____

- **Legal Authority Verified:** ☐ Yes ☐ No **Documentation Required:** ☐ Yes ☐ No

SECTION 6: Financial Policy and Payment Agreement

I understand that by signing this document I am entering a financial agreement with GKB Neuropsychology for all evaluation, consultation, and related services, whether provided in office, by telehealth, or through another authorized location.

I understand I am responsible for all fees for services provided, including deductibles, copayments, coinsurance, and any amount not covered by insurance. If I choose not to use insurance or have no coverage, I agree to pay the full fee discussed in advance.

I understand it is my responsibility to verify benefits and obtain required authorizations before services are rendered. Information from my insurance company is not a guarantee of payment. If my insurer denies or reduces payment, I remain responsible for the balance.

Payment is due at the time of service unless prior arrangements are made. When billing is directed to a facility, attorney, or agency, I remain responsible for any unpaid portion.

Fees for evaluation include interview, test administration, scoring, interpretation, report preparation, and feedback. Additional professional services (letters, extended calls, record review, legal consultation, or testimony) may be billed separately at the standard rate.

If an account becomes past due, reasonable steps may be taken for collection, including referral to a collection service, which may receive limited identifying and billing information.

I agree to provide at least 48 hours' notice for cancellations. Late cancellations or missed appointments may incur a fee not covered by insurance.

I authorize GKB Neuropsychology to release only the minimum necessary information required for billing, claims processing, or payment purposes to my insurance company or other responsible party, consistent with HIPAA privacy regulations.

By signing below, I acknowledge that I have read and understand this Financial Policy and Payment Agreement and agree to its terms.

Patient/Guardian Signature: _____ **Date:** _____

SECTION 7: General Informed Consent for Services

Nature of Services
I understand that I am seeking professional services from GKB Neuropsychology focused on neuropsychological evaluation and related consultation. Services may include interviews, standardized testing, review of records, and feedback regarding findings and recommendations. Evaluations may occur in office or by secure telehealth when appropriate.

These services are for assessment and consultation, not ongoing psychotherapy or crisis care. If ongoing treatment or medication management is needed, referrals may be provided.

Voluntary Participation
My participation is voluntary. I may ask questions at any time, decline to answer, or stop the evaluation. If I withdraw before completion, I am responsible for services already provided.

Confidentiality and Its Limits
Information shared with GKB Neuropsychology is confidential and protected by law. Records are released only with written authorization, except when disclosure is required or permitted by law—such as serious risk of harm to self or others, suspected abuse or neglect, a court order, or insurance and quality-review requirements.

When evaluations are requested by a physician, attorney, insurer, or other third party, relevant findings may be shared with that party as authorized. For self-referrals, reports are released only to me unless I authorize otherwise.

I understand that raw test materials are professional tools and are not released directly to patients or non-psychologist third parties. Upon written authorization, they may be shared with another licensed psychologist for professional review.

Telehealth Services
Portions of evaluation or feedback may be conducted by secure video or phone when clinically appropriate. Telehealth carries potential privacy risks. I agree to ensure privacy, stable connection, and a distraction-free setting. If technical problems occur, sessions may be rescheduled. For emergencies, I will call 911 or go to the nearest emergency department.

I understand that by consenting to participate in telehealth, I accept these terms and acknowledge that the same confidentiality standards apply as in-person services.

Electronic Communications
I understand that email and text communications are not fully secure. They may be used only for scheduling and administrative matters, not for emergencies or clinical discussions. I consent to email communication: ☐ No ☐ Yes

I acknowledge that I have read, understood, and agree to the above informed consent.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Printed Name: _____

Relationship to Patient: _____

Section 8: HIPAA Acknowledgement

I acknowledge that I have been provided with a copy of this practice's Notice of Privacy Practices, which describes how my protected health information may be used and disclosed.

I understand that:

- I have the right to review the Notice before signing this acknowledgment
- The practice reserves the right to change privacy practices described in the Notice
- I may request a current copy of the Notice at any time
- I may revoke this acknowledgment in writing, except to the extent action has already been taken
- I acknowledge receipt of, and understanding of, this practice’s Notice of Privacy Practices.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Printed Name: _____