# MidMichigan Neuropsychology Associates, P.L.C.

4705 Towne Centre Road
Medical Arts I, Suite 304
Saginaw, MI 48604-2821

Phone: (989) 921-5100
Fax: (989) 921-5104
Email: neuropsych@mnabrain.com


## ADULT HISTORY FORM

(Revised 3/2014)

DATE: _____

FIRST NAME: _____ LAST NAME: _____

MIDDLE INITIAL: _____ PREVIOUS NAME: _____

IF P.O. BOX, YOU MUST PROVIDE A PHYSICAL ADDRESS.

ADDRESS: _____ HOME #: _____

_____ MOBILE #: _____

_____ E-MAIL: _____

BIRTHDATE: _____ CURRENT AGE: _____ SEX: _____

SOCIAL SECURITY #: _____ ARE YOU RIGHT OR LEFT HANDED? _____

DRIVER'S LICENSE NUMBER: _____ STATE ISSUED: _____

IF YOU HAVE A LEGALLY APPOINTED GUARDIAN PLEASE PROVIDE:

GUARDIAN'S FULL NAME: _____

ADDRESS: _____ HOME #: _____

_____ MOBILE #: _____

_____ E-MAIL: _____

WHY HAVE YOU BEEN REFERRED TO OUR PRACTICE?: _____

WHO REFERRED YOU TO OUR PRACTICE?: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

FAMILY DOCTOR: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

IF YOU ARE SEEING ANY OTHER DOCTORS, PLEASE LIST THEM ON ANOTHER PAGE. BE SURE TO INCLUDE THE

ADD ADDRE ADDRESS, PHONE #, FAX #, AND E-MAIL ADDRESS.

## MEDICAL HISTORY

BRIEFLY DESCRIBE YOUR CURRENT MEDICAL PROBLEM(S), CONDITION(S) AND DIAGNOSES:

_____

_____

_____

_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CIRCLE)

High Blood Pressure
Chronic Pain/Chronic Headaches
Heart Disease
Lung Disease
Thyroid Disease
Kidney Disease
Liver Disease
Exposure to Harmful Chemicals/Gases or Other Poisons
Ulcer/Colitis/Gastritis/Irritable Bowel
Diabetes/Hypoglycemia
Skin Problems
Anemia/Blood Disorders
Cancer
Rheumatoid Disorders
Sexually Transmitted Disease
HIV Infection or AIDS

HAVE YOU EXPERIENCED? (PLEASE CIRCLE)

Loss of Consciousness
Head Injury
Seizures
Stroke
Encephalitis
Meningitis
Serious Accident/Injury

HAVE YOU EXPERIENCED? (PLEASE CIRCLE)

Significant Depression
Severe Anxiety
Thoughts of Suicide
Chronic Fatigue
Physical/Sexual Abuse
Eating Disorder
Sleep Disorder
Sexual Dysfunction
Marital Problems
Counseling
Psychiatric Hospitalization

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR FOODS? (Please List) _____

_____

_____

IF YOU HAVE EVER BEEN HOSPITALIZED OR HAD SURGERY PLEASE STATE:

REASON: _____

WHEN: _____ WHERE: _____

IF HOSPITALIZED MORE THAN ONCE, LIST ALL REASONS, WHEN AND WHERE ON ANOTHER PAGE.

IF YOU HAVE EVER HAD A PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL EVALUATION BEFORE PLEASE STATE.
DOCTOR'S NAME: _____

WHEN: _____ WHERE: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER, HERBAL, AND VITAMIN/MINERAL/DIETARY SUPPLEMENTS
(BRING ALL MEDICATIONS THAT YOU MAY NEED DURING THE APPOINTMENT WITH YOU):

MEDICATION NAME DOSAGE (INCLUDE STRENGTH AND FREQUENCY)

_____

_____

_____

_____

_____

_____

HAVE YOU EVER BEEN IN COUNSELING? (PLEASE CIRCLE) YES NO

IF YES, PLEASE STATE REASON(S) AND LOCATION WHERE COUNSELING WAS RECEIVED: _____

_____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

DO YOU NOW OR HAVE YOU PREVIOUSLY USED ALCOHOL? (PLEASE CIRCLE) YES NO

AT WHICH AGE DID YOU BEGIN DRINKING?: _____

WHAT DO YOU DRINK? (e.g. BEER, WINE, LIQUOR): _____

HOW FREQUENTLY DO YOU DRINK? (PLEASE CIRCLE)

Daily Once a week More than once a week Once every two weeks Less than every two weeks Rarely

AT THE TIME OF YOUR LIFE THAT YOU DRANK MOST HEAVILY, HOW MUCH WERE YOU DRINKING?

_____

HAVE YOU EVER HAD PROBLEMS WITH YOUR HEALTH, JOB, MARRIAGE, FAMILY, FINANCES OR LEGAL PROBLEMS DUE TO YOUR ALCOHOL USE? (IF YES, PLEASE EXPLAIN): _____

_____

DO YOU NOW OR HAVE YOU PREVIOUSLY USED STREET DRUGS? (IF YES, PLEASE EXPLAIN): _____

_____

DO YOU SMOKE? (IF YES, WHEN DID YOU START AND HOW MUCH DO YOU SMOKE NOW): _____

_____

## EDUCATIONAL HISTORY

YEARS OF EDUCATION (PLEASE CIRCLE): Some High School (# of years _____)

GED High School Associate's Degree Bachelor's Degree Master's Degree Doctoral Degree

HIGH SCHOOL: _____

CITY/STATE: _____ LAST YEAR ATTENDED: _____

COLLEGE/UNIVERSITY: _____

CITY/STATE: _____ LAST YEAR ATTENDED: _____

IF YOU GRADUATED FROM HIGH SCHOOL, PLEASE INDICATE YOUR GRADE AVERAGE (GPA): _____

IF YOU GRADUATED FROM COLLEGE/GRADUATE SCHOOL, WHAT WAS YOUR MAJOR?: _____

_____

HAVE YOU EVER BEEN INFORMED THAT YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE):

Learning Disability Attention Deficit Disorder Hyperactivity Behavioral Problems

WERE YOU EVER HELD BACK A GRADE IN SCHOOL? (PLEASE CIRCLE): YES NO

WHAT GRADE?: _____

## OCCUPATIONAL HISTORY

ARE YOU CURRENTLY EMPLOYED? (PLEASE CIRCLE): YES NO

IF YES, EMPLOYER: _____ HOW LONG?: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

POSITION: _____

_____

WHERE WAS YOUR PREVIOUS EMPLOYMENT? (OR IF RETIRED WHAT WAS YOUR PRIMARY OCCUPATION?)

NAME: _____ HOW LONG?: _____

_____ PHONE #: _____

_____ FAX #: _____

## SOCIAL HISTORY

CURRENT MARITAL STATUS: (PLEASE CIRCLE): Single Married Separated Divorced Widowed

HOW LONG HAVE YOU BEEN/WERE YOU MARRIED?: _____

CURRENT SPOUSE'S NAME: _____

HOW MANY TIMES HAVE YOU BEEN MARRIED?: _____

HOW MANY CHILDREN DO YOU HAVE? (INCLUDE NAME, AGE AND SEX): _____

_____

PLEASE DESCRIBE YOUR CURRENT LIVING SITUATION (WHO YOU LIVE WITH, ETC.):

_____

WHAT DO YOU DO FOR RELAXATION, LEISURE OR HOBBIES?: _____

_____

ARE YOU CURRENTLY EXPERIENCING STRESS DUE TO FAMILY PROBLEMS, WORK RELATED PROBLEMS, FINANCES, TRAUMATIC EVENTS, OR OTHER CAUSES? (PLEASE DESCRIBE):

_____

_____

HAVE YOU EVER BEEN ARRESTED? (PLEASE EXPLAIN): _____

_____

_____

ARE YOU CURRENTLY INVOLVED IN A LAWSUIT, CRIMINAL MATTER OR OTHER LEGAL PROCEEDING? (PLEASE EXPLAIN): _____

_____

_____

ATTORNEY'S NAME: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

DO YOU HAVE A CASE MANAGER? (PLEASE CIRCLE): YES NO

CASE MANAGER'S NAME: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

IS THERE ANYTHING ELSE YOU WISH THE DOCTOR TO KNOW ABOUT YOUR PHYSICAL OR PSYCHOLOGICAL HEALTH HISTORY?: _____

_____

_____

_____

_____

IN CASE OF AN EMERGENCY, WHO WOULD YOU LIKE US TO CONTACT?

NAME: _____ RELATIONSHIP TO YOU: _____

ADDRESS: _____ HOME #: _____

_____ MOBILE #: _____

_____ E-MAIL: _____

NEAREST RELATIVE NOT LIVING WITH YOU:

NAME: _____ RELATIONSHIP TO YOU: _____

ADDRESS: _____ HOME #: _____

_____ MOBILE #: _____

_____ E-MAIL: _____

# MidMichigan Neuropsychology Associates, PLC

## Patient Authorization, Assignment, and Agreement For Services Performed

Patient Name (Please Print): _____

I hereby authorize MidMichigan Neuropsychology Associates, PLC, neuropsychologists and/or its designees to release to my insurance company and/or third-party payor(s) and/or external review agency(s) such information contained in my patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history or illness or diagnostic and therapeutic information including any testing and/or treatment for AIDS, AIDS-Related Complex (ARC) or HIV infection (MI 1989 Public Act 174). This authorization expires upon full payment of insurance benefits unless previously revoked, and may be revoked at any time except to the extent that action has been taken by MidMichigan Neuropsychology Associate, PLC in reliance thereon. I certify information furnished for this claim to be true and correct.

### ASSIGNMENT

I assign to MidMichigan Neuropsychology Associates, PLC, its neuropsychologists and/or designees all rights to benefits, insurance proceeds, settlement payments or judgements I may be entitled for services rendered.

### AGREEMENT

I understand that any amounts not paid by my insurance are my responsibility. Also, I understand that bills not paid within 30 days of services rendered by MidMichigan Neuropsychology Associates, PLC, may be charged 1.5% service charge per month (18% APR ) on any unpaid balance.

### MEDICARE PATIENTS

I request payment to MidMichigan Neuropsychology Associates, PLC of authorized Medicare benefits for any services furnished by MidMichigan Neuropsychology Associates, PLC, rendered on my behalf. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, its agents and other carriers, any information needed to determine these benefits or benefits for related services. This request is effective until revoked in writing.

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Closest Relative or Legal Guardian (if Applicable)

Signature of Witness Relationship

# Notice of Privacy Practices Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

## What is HIPAA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The
Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medicals records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by
following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

## What is individually identifiable health information (IIHI)?

Any health information you provide, including your mailing address, information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

## The following categories best describe the different ways in which we may use and disclose your IIHI:

Treatment, Appointment Reminders, Release of Information to Family/Friends,
Payment, Treatment Options, Disclosures Requires by Law
Healthcare Operations, Health Related Benefits and Services

## The following categories describe unique situations in which we may use or disclose your IIHI:

Public Risks, Health Oversight Activities, Lawsuits, Law Enforcement
Serious Health Threats/Safety, Research

***You may request to view our full Notice of Privacy at anytime.***

The undersigned Patient or legally authorized representative "Agent" of the Patient acknowledges that he or she personally received or was offered a copy of the MidMichigan Neuropsychology Associates Notice of Privacy Policies.

_____ _____

Printed name Witness

_____ _____ _____

Signature Date

# Map to

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4705 Towne Center Road
Suite 304
Saginaw, MI 48604