Dr. Ilyse O'Desky
26 Linden Avenue, Springfield, NJ 07081
(973) 376-5511

NEW PATIENT INFORMATION FORM (ADULT)

DATE: ____________________

PATIENT'S NAME: ____

ADDRESS: ____

____

____

HOME TELEPHONE #: ____

WORK TELEPHONE #: ____

PATIENT'S DATE OF BIRTH: ____

REFERRING PHYSICIAN OR PERSON: ______________________________________

****

Reason for Referral: ____

____

____

Previous Testing (when and by whom): ____

____

____

____

Date of Last Physical Exam: ____

Problems? ____

____

____

Current Medications: ____

____

____

List Serious Illnesses/Injuries/Hospitalizations/Surgeries/Chronic Conditions:

Age of Occurrence Incident

____

____

____

____

Developmental History: Please check if there were any problem areas

___ Prenatal History ___ Language skills ___ Gross motor skills

___ Fine motor skills ___ Social skills

Level of Education: Highest Degree Obtained

___ Grade School ___ High School ___ College/University ___ Graduate School

Occupational History:

Job Title	Years Employed

Please check if patient has had any of the following:

_____ Loss of Consciousness
_____ Lead Poisoning/Toxic Ingestion
_____ Headaches
_____ Sleep Difficulties
_____ Tics/Twitching
_____ Self-Injurious Behavior
_____ Unexplained or Frequent Falls
_____ Asthma or Allergies
_____ Clumsiness
_____ Eating Difficulties
_____ Fights with Others
_____ Difficulty caring for basic needs (feeding or hygiene)

Please check if there is a family history of any of the following:

_____ Epilepsy or other seizure disorders
_____ Attention or Memory Problems
_____ Psychiatric Disorders
_____ Learning Disorders

Notice of Patient Privacy Practices

I acknowledge that I have received a copy of the practice's notice of patient privacy practices.

Signature:_______________________________________ Date:__________________________

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Permission of Patient Contact
(Effective April 14, 2003 under Federal Law)

Contact Information: This information will allow this office to contact you with appointment reminders or other information relevant to billing or treatment.
Please fill out the bottom portion in its entirety.

Please list two phone numbers that we may use to contact you:

1. Phone #: ________________________________ 2. Phone #: ___________________________

In the event that Dr. O'Desky or her associate is unable to reach you concerning your status with this office (i.e. appointment, test results, billing statements, etc.) may we leave a message on your:

Home answering machine   Yes ______   No ______
Cellular voice mail   Yes ______   No______
Work voice mail   Yes ______   No______

If I need to contact you at work and you are unavailable, may I leave a message with the receptionist for a call back to my office?   Yes   No

Please list the names of any person or persons that may be involved in your treatment that I may be permitted to discuss anything concerning your medical status (i.e. practitioner or, parent, etc). Please note, if a name is not listed, I am required by law to protect your information and I will not discuss anything pertaining to your healthcare with that unlisted person.

Name: _______________________   Name _______________________
Address: _______________________   Address _______________________
_______________________   _______________________
Phone number _______________________   Phone number _______________________

Patient Name: __________________________________   Date: _____/__ /______

Signature: _____________________________________   Relationship: _________________
(Parent or Guardian if patient is under 18 yrs old)

* Please keep this report in a secure place. As a courtesy, upon signing this release form one copy of this report will be forwarded to a source you designate on this form. You are free to make additional copies to send to other professionals. If any additional copies are required from us, a $50 fee will be required for each copy.

**Please note that effective April 14, 2003, the law requires a written notice for any changes or additions to the information that you have listed above. Any verbal communication of changes or additions will not be honored by our office.

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Neuropsychological Testing Service

GUARANTEE OF PAYMENT: For value received, the undersigned guarantor and/or patient (hereinafter the "Responsible Party") promises to pay to Dr. Ilyse O'Desky all charges incurred for services rendered to the Responsible Party.

Dr. O'Desky will provide the Responsible Party with a form to submit to the insurance company for reimbursement. Dr. O'Desky cannot guarantee that each service will be covered or what percentage will be covered. However, it is understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by Dr. O'Desky and it is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Responsible Party.

A minimum of 24 hours notice is required for cancellation of appointments. If this notice is not received, the Responsible Party may be charged for the full amount of time which was reserved for the appointment at the agreed upon rates. Insurance may not be billed for missed/canceled appointments.

In the event this account is turned over to a collection agency, the Responsible Party hereby agrees to pay all costs of collection including, but not limited to, 35% of the fee to be collected and court costs. The Responsible Party agrees to be bound by the terms and conditions of this account with Neuropsychological Testing Center.

In the event that the bank returns the check to Dr. O'Desky, the Responsible Party will be billed for the initial amount of the check as well as a $25.00 fee for processing the returned check.

Dr. O'Desky will work with the Responsible Party regarding payment (e.g., setting up a payment plan). Dr. O'Desky expects full payment within ninety (90) days of the date of service unless prior arrangements have been made. The Responsible Party hereby agrees that accounts not paid within thirty (30) days will be charged a late fee of $15.00 and will accrue interest at the rate of 1.5% per month (18% A.P.R. - a minimum of $1.00 will apply). The Responsible Party bears ultimate financial responsibility for all services rendered to the Patient/Responsible Party.

NOTE: Testing includes time for (1) administering and (2) scoring the tests, (3) reviewing records, (4) preparing the report, and (5) discussion of the results (feedback). In nonforensic/nonmedical cases, this will typically add 3-4 hours to the actual testing time. Forensic/medical-legal cases typically require even more time and generally include a more extensive record review and consultation(s) with attorney(s), etc.

If you have any questions, please speak with Dr. O'Desky. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

_________________________________ Date: ______________
Patient Signature:

_________________________________ Date: _____________
Parent/Guardian Signature
(if patient is unable to sign, contact Dr. O'Desky)