BLUE MOUNTAIN PSYCHOLOGY, PLLC

Please complete all pages prior to your first appointment. Thank you.

CHILD/ADOLESCENT CLIENT/PATIENT/EXAMINEE INFORMATION

Today's date: ___/___/_____	**Patient Name:** _____ **First** **Last** **Middle**	**Date of birth (DOB):** ___/___/_____
Patient's address:		**Email:**
Preferred contact #: ( )	Patient's SSN: _____-_____-_____	Previous patient: ☐ Yes Dates:_____ ☐ No
Patient's race:	Patient's ethnicity:	☐ Male ■ Female ☐ _____
Reason for referral (reason and/or diagnosis required):		
School name:		
Father's name:	Father's SSN: _____-_____-_____	Father's DOB: ___/___/_____
Father's address (if different):		Father's employer:
Father's work phone: ( )	Father's cell phone: ( )	
Mother's name:	Mother's SSN: _____-_____-_____	Mother's DOB: ___/___/_____
Mother's address (if different):		Mother's employer:
Mother's work phone: ( )	Mother's cell phone: ( )	
Who has physical custody of the patient?:	If joint custody, please indicate schedule:	
Emergency contact name:	Emergency contact phone number: ( )	
Patient's Primary Care Physician (PCP):	PCP address:	PCP phone: ( )

Referral source:	Other physicians and other professionals involved in the patient's care for the current services:	
Allergies:	Current medications:	
Is referral auto related?:	If so, date of injury: ___/___/_____	
Is referral work related?:	If so, date of injury: ___/___/_____	

BMNA Staff Only

Diagnosis Codes
ICP-9: _____ _____ _____ _____
DSM-IV-TR: Axis I_____ Axis II_____ Axis III_____ Axis IV_____ Axis V_____

Services Provided
___90791 ___/___/_____ ___90832 ___/___/_____ ___90834 ___/___/_____
___96101 ___/___/_____ ___96118 ___/___/_____ _____ ___/___/_____

****Please bring your insurance card to the first appointment****

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INSURANCE INFORMATION

A copy of the patient's insurance card does not replace this page. Please complete as much information as possible including a phone number for the insurance company. Thank you.

Today's Date: __/__/____	**Patient Name:** _____ **First Last Middle**	**Patient Date of Birth:** __/__/____
Primary insurance carrier:	Insurance phone#: ( )	Claims mailing address:
Contract #:	Group#:	
Subscriber name: _____ First Last Middle	Subscriber's Date of Birth: ___/___/_____	Subscriber employer:
Date verified (**Staff only**): ___/___/_____	Contact person:	Call notes:
Secondary insurance:	Insurance phone#: ( )	Claims mailing address:
Contract #:	Group#:	
Subscriber name (if different): _____ First Last Middle	Subscriber's Date of Birth: ___/___/_____	Subscriber employer:
Date verified (**Staff only**): ___/___/_____	Contact person:	Call notes:
Other insurance (e.g., auto):	Insurance phone#: ( )	Claims mailing address:
Contract #:	Group#:	
Subscriber name (if different): _____ First Last Middle	Subscriber's Date of Birth: ___/___/_____	Subscriber employer:
Date verified (**Staff only**): __/__/____	Contact person:	Call notes:

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Client/Patient/Examinee Name: _____ **Date:** _____

BMNA is located in a professional office building where noise must be kept to a minimum and unruly behavior is not allowed. Children must be accompanied by an adult at all times in this building.

Parents/Guardians are responsible for all children under their care. Please arrange for childcare of siblings and other children if needed, and take your child (children) out of the building if he or she becomes unruly or too noisy at any time (e.g., while in the waiting room).

We apologize for any inconvenience. Thank you for your understanding, and for helping us assure quality care of all individuals.

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: _____ **Date:** ___/___/_____
(if 13+ years old)

Signature of guardian (if applicable): _____ **Date:** ___/___/_____

Staff signature: _____ **Date:** ___/___/_____

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Client/Patient/Examinee Name: _____ **Date:** _____

Disclosures

Consent to treatment

1) You (the **Client/Patient/Examinee**) have a right to refuse treatment and all other services offered by **Blue Mountain Neuropsychological Associates, PLLC**, hereafter referred to as **BMNA**
2) The **Client/Patient/Examinee** has responsibility to choose the provider and treatment modality that best suits their needs
3) The theoretical orientation used by BMNA staff is an eclectic one
4) I hereby consent to receiving services from BMNA

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: (if 13+ years old) _____ **Date:** ___/___/_____

Signature of guardian (if applicable): _____ **Date:** ___/___/_____

Staff signature: _____ **Date:** ___/___/_____

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Client/Patient/Examinee Name: _____

Notice of Privacy Practices Acknowledgement
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
PAGE ONE OF TWO

Confidentiality

1) Your (the patient's) confidential health care information cannot be disclosed to any other person without written authorization from you (the patient) or a legal representative
2) You have a right to receive an accounting of disclosures of health care information made by a health care provider or a health care facility in the six years before the date on which the accounting is requested, except for disclosures:
    a. To carry out treatment, payment, and health care operations;
    b. To the patient of health care information about him or her;
    c. Incident to a use or disclosure that is otherwise permitted or required;
    d. Pursuant to an authorization where the patient authorized the disclosure of health care information about himself or herself;
    e. Of directory information;
    f. To persons involved in the patient's care;
    g. For national security or intelligence purposes if an accounting of disclosures is not permitted by law;
    h. To correctional institutions or law enforcement officials if an accounting of disclosures is not permitted by law; and,
    i. Of a limited data set that excludes direct identifiers of the patient or of relatives, employers, or household members of the patient
3) In the case of suspected neglect or abuse of a child or elderly person, information may be disclosed without your consent
4) In the case of potential harm to self, others, or property, information may be disclosed to others without your consent
5) Please see RCW 70.02.050 for information about possible disclosure without patient authorization
6) I hereby authorize BMNA to release medical and financial information pertaining to services rendered to third party insurance carrier(s) for charges incurred during my receipt of BMNA services
7) I hereby authorize disclosure of any information that BMNA deems necessary to provide me with proper treatment or other services

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Notice of Privacy Practices Acknowledgement
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
PAGE TWO OF TWO

NOTICE

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting an authorized representative of Blue Mountain Neuropsychological Associates, PLLC (BMNA).

Records are maintained for at least eight years beyond the date of service. Records for minor children are maintained at least until the **Client/Patient/Examinee** becomes 24 years of age, or for eight years, whichever is longer.

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: (if 13+ years old) _____ **Date:** ___/___/_____

Signature of guardian (if applicable): _____ **Date:** ___/___/_____

Staff signature: _____ **Date:** ___/___/_____

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Client/Patient/Examinee Name: _____

Financial Obligations
PAGE ONE OF TWO

Duplicating or searching for records

1) A charge of $1.09 per page will be charged for the first 30 pages; 82 cents per page will be charged for all other pages
2) There is a $24 clerical fee for searching and handling of records
3) Reviewing and/or Editing of records is assessed at a rate of approximately $225 per hour

Charge for clinical services

1) The "hourly" rate for services received is approximately $225
    a. "Hourly" is defined as a period of 45-50 minutes
2) Intake appointments are charged at a rate of $338
3) Consistent with standard fees, the following grid lists charges for BMNA products & services:

Psychological or Forensic* evaluation	$900
Neuropsychological evaluation	$1,800
Consultation	$275 for any portion of each hour
Deposition or testimony	a) Deposition: a. $770 for first hour i. $330 for any portion of each additional hour b) Live testimony: **Charges begin upon my arrival at the arranged location and start time, and last until my departure** a. $770 for first hour i. $330 for any portion of each additional hour **ii. Minimum charge of $3,500** ***b. $3,500 is billed to the payor in cases of cancellation or no-show***

***Insurance will not be billed for Forensic (includes parenting competency) Evaluations**

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Financial Obligations
PAGE TWO OF TWO

4) If you have insurance that is accepted by this company, your insurance carrier will be billed for amounts due
    a. You are fully responsible for any amounts rejected or otherwise not covered by your insurance company
    b. If BMNA has not secured payment from your insurance company within 90 days of billing, you will be responsible for the bill
5) Reports may be withheld until balance is paid in full
6) I hereby authorize that the benefits payable be directly paid to BMNA by third party carrier(s)

Failure to show for scheduled appointments

1) Failure to show (*no*-show) for scheduled appointments, or cancelling a scheduled appointment less than 48 hours in advance, will result in a charge of $275 per occurrence
    a. **Clients/Patients/Examinees** who present greater than 15 minutes late for a scheduled appointment will be considered a *no-show* and billed accordingly
    b. This charge cannot be billed to your insurance provider
    c. All outstanding charges must be paid before additional appointments will be scheduled
2) Copayments are due at time of appointment unless other arrangements have been made
3) Cash, check, and credit cards (3% transaction fee applies) are acceptable forms of payment
    a. There is a$30 fee on each returned check
    b. If your account is delinquent for 90 or more days, services may be discontinued and your account may be forwarded to a collection agency
        i. An interest charge of 1.2% per month will be applied to all outstanding balances
        ii. You are responsible for all collection costs and attorney fees if applicable
4) You are responsible for notifying BMNA of any changes to your insurance carrier or coverage

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: (if 13+ years old) _____ **Date:** ___/___/_____

Signature of guardian (if applicable): _____ **Date:** ___/___/_____

Staff signature: _____ **Date:** ___/___/_____

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Disclosure Authorization
Release of Information

(Fill this out if you know that BMNA staff will need to communicate with the client's/patient's/examinee's family physician, transportation services, or others working for their care)

Client/Patient/Examinee Name: _____ **Date:** _____

I authorize Blue Mountain Neuropsychological Associates, PLLC to disclose my confidential medical information to the following entity or entities:

_____
_____

The following types of information will be disclosed:

__All available records
__Diagnoses
__Treatment plans
__Other (please describe): _____

This disclosure authorization will expire on: ___/___/_____
Additional information regarding expiration of this authorization: _____

Signature of Client/Patient/Examinee: _____ **Date:** ___/___/_____
(if 13+ years old)

Signature of guardian (if applicable): _____ **Date:** ___/___/_____

Staff signature: _____ **Date:** ___/___/_____

Disclosures to financial institutions or employers for purposes other than payment shall expire after 90 days unless renewed by the patient. Disclosures to department of corrections, while patient is under supervision of the department of corrections, expires at end of term of supervision or end of required treatment. Please see RCW 70.02.050 for information about possible disclosure without patient authorization.

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Client/Patient/Examinee Name: _____ **Date:** _____

Use of data for research and clinical demonstration

I authorize Blue Mountain Neuropsychological Associates, PLLC to use confidential information that is gathered about me or my dependent (if **Client/Patient/Examinee** is a child) while providing professional services. Such information may be used in research studies and for purposes of clinical demonstration (e.g., training students and other professionals) to help advance scientific practices. **My personal information will be kept confidential and anonymous**:

Signature of Client/Patient/Examinee (if 13+ years old): _____ **Date:** ___/___/_____

Signature of guardian (if applicable): _____ **Date:** ___/___/_____

Staff signature: _____ **Date:** ___/___/_____

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Permission to Audio/Video Record

Client/Patient/Examinee Name: _____ Date: _____

I _____ authorize Dr. Jameson Lontz and Blue Mountain Neuropsychological Associates, PLLC to audio and/or video record communications as part of rendering professional services.

This authorization will expire on: ___/___/_____
Additional information regarding expiration of this authorization: _____

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____
(if 13+ years old)

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Release of Claims

Client/Patient/Examinee Name: _____ Date: _____

In consideration of services provided by BMNA or Dr. Jameson C. Lontz, the client/patient/examinee or his/her delegate whose signature is below this paragraph releases and waives any and all claims they might possibly have against BMNA (PLLC) or Dr. Jameson C. Lontz, whether aware of them or not. In legal terms, this means that the client/patient/examinee or his/her delegate whose signature is below this paragraph completely releases and forever discharges BMNA (PLLC), Dr. Jameson C. Lontz, and respective directors, officers, agents, representatives, owners, employees, past and present, from all claims, demands, rights, actions, obligations, and causes of action of any and every kind, nature and character, known or unknown, arising from or in any way connected to all actions, omissions, and conduct during the receipt of services by BMNA (PLLC) or Dr. Jameson C. Lontz.

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____
(if 13+ years old)

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Your Child's Name:_____ Today's Date:_____

Please complete all sections prior to your first appointment

Social History

Where was your child born /Raised/What is his or her date of birth?_____

_____

Describe the relationship that your child has with each of his/her parents. Does your child have any problems with either parent? Has your child ever been the victim of neglect or abuse (physical, sexual, emotional/verbal)?_____

_____

Who has legal custody of the child? With whom does the child live?_____

_____

Does your child have any brothers or sisters; how many; and, how is your child's relationship with each of them? Where is your child in the birth order?_____

_____

Are you aware of any family history of mental illness, neurological problems, substance abuse?

_____

_____

What is your child's school grade, educational history, and grade point average? Any special education classes? Was your child ever suspended from school? Is s/he (has s/he ever been) in any extracurricular (e.g., sports) activities?_____

_____

What type of work do the parents of your child do? If unemployed, when did either of you last work, and what type of work did you do? Do either of you have any military experience?_____

_____

_____

What is your marital status and relationship history?_____

_____

Who currently lives in your home?_____

Spiritual history and other current engagements, e.g., church, racial, ethnic, and other cultural factors that affect your child's presenting concerns:_____

_____

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Who are the most supportive people in your child's life?_____

What does your child do for fun?_____

Medical History

Did you carry this baby to term? If not, how many weeks?_____
Birth complications?_____
Any childhood illnesses (e.g., lots of ear infections)?_____

At what age did your child do the following?:

Sit without help_____
Crawl_____
Walk _____
Show a clear hand preference_____
Fasten buttons, zippers_____
Build with blocks_____
Sit still for t.v. or stories_____

Play with puzzles_____
Draw pictures_____
Play with other children_____
Say single words meaningfully_____
Combine two or more words_____
Use sentences_____

Any concerns with your child's learning (compared to other children)?_____
Head injuries?_____
Surgeries?_____
Current and past illnesses or conditions that you have not mentioned?_____
_____
How does your child cope with stress?_____
How does your child express anger?_____

Mark any of the following that are current areas of concern for your child:

- ☐ Sleep
- ☐ Diet
- ☐ Energy level
- ☐ Weight
- ☐ Concentration
- ☐ Leisure
- ☐ Relationships
- ☐ School functioning

All current medications, over the counter and prescribed (continue on back of last page if necessary):_____
_____

Is your child currently seeing any other doctors? If so, what for? Date of last physical exam:
_____

Alcohol and Other Substance Use

Are you or anyone else in the home a smoker? If so, how many per day?_____
Did you use tobacco, alcohol, or any medications during pregnancy with your child? If so, how often, and how much_____
_____

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day?_____

How often do you drink alcohol; how much per occasion; when in your life were you drinking the most; how long did that period last?_____
_____

Have you ever used illegal drugs to get high, sleep better, lose weight, or change your mood? Which drugs; how often; when in your life were you using the most; how long did that period last?_____
_____
Do you have any concerns that your child may be using drugs?_____

Legal History
Has your child ever been arrested? If so, what for? Was s/he convicted? What was the sentence for each conviction (e.g., fines, jail time?)_____
_____

Have you ever been arrested (during childhood, adolescence, or adulthood)? If so, what for? Were you ever convicted? What sentencing have you received (e.g., fines, jail time)?
_____
_____

Psychiatric History
Has your child ever been in therapy/counseling before; if so, with whom, how long, and what were the reasons?_____
Has your child ever been a patient in a psychiatric hospital; if so, where, how long, and what were the reasons?_____
_____

Has your child ever expressed thoughts of hurting or killing herself/himself or someone else?
_____

Nature of Referral
What are the reasons you brought your child here? Who referred you here?_____
_____
How long have you had the concerns that caused you to bring your child here?_____
_____

Treatment Goals and Expectations
What are you hoping to gain from receiving services here?_____
_____
How will you know when you are ready to end your child's treatment?_____
_____

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***Extreme*) that tells about your child best in the past 30 days.**

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

36-item version, proxy-administered

Patient Name: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female **Date:** _____

This questionnaire asks about difficulties due to health/mental health conditions experienced by the person about whom you are responding in your role as friend, relative, or carer. Health conditions include **diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.** Think back over the **past 30 days** and, to the best of your knowledge, answer these questions thinking about how much difficulty your friend, relative, or carer had while doing the following activities. (Note: the questionnaire uses the term "relative" to mean "friend," "relative," or "carer.") For each question, please circle only **one** response.

H4[a]	I am the _____ (choose one) of this person	1 = husband or wife ☐ 2 = parent ☐ 3 = son or daughter ☐ 4 = brother or sister ☐	5 = other relative ☐ 6 = friend ☐ 7 = professional carer ☐ 8 = other (specify) ☐

Numeric scores assigned to each of the items:		1	2	3	4	5	*Clinician Use Only* Raw Item Score	Raw Domain Score	Average Domain Score
In the last 30 days, how much difficulty did your relative have in:									
Understanding and communicating									
D1.1	Concentrating on doing something for ten minutes?	None						___/30	___/5
D1.2	Remembering to do important things?	None							
D1.3	Analyzing and finding solutions to problems in day-to-day life?	None							
D1.4	Learning a new task, for example, learning how to get to a new place?	None							
D1.5	Generally understanding what people say?	None							
D1.6	Starting and maintaining a conversation?	None							
Getting around									
D2.1	Standing for long periods, such as 30 minutes?	None						___/25	___/5
D2.2	Standing up from sitting down?	None							
D2.3	Moving around inside their home?	None							
D2.4	Getting out of their home?	None							
D2.5	Walking a long distance, such as a kilometer (or equivalent)?	None							
Self-care									
D3.1	Washing his or her whole body?	None						___/20	___/5
D3.2	Getting dressed?	None							
D3.3	Eating?	None							
D3.4	Staying by himself or herself for a few days?	None							

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Numeric scores assigned to each of the items:		1	2	3	4	5	Clinician Use Only: Raw Item Score	Raw Domain Score	Average Domain Score
Because of their health condition, in the past 30 days, how much difficulty did your relative have in									
Getting along with people									
D4.1	Dealing with people he or she does not know?	None				Extreme or lo			
D4.2	Maintaining a friendship?	None				or			
D4.3	Getting along with people who are close to him or her?	None				or		25	5
D4.4	Making new friends?	None				or lo			
D4.5	Sexual activities?	None				or			
Life activities—Household									
D5.1	Taking care of his or her household responsibilities?	None				Extreme or			
D5.2	Doing his or her most important household tasks well?	None				Extreme or			
D5.3	Getting all the household work done that is needed?	None				or		20	5
D5.4	Getting the household work done as quickly as needed?	None				or			
Life activities—School/Work									
If your relative works (paid, non-paid, self-employed) or goes to school, complete questions D5.5-D5.8, below. Otherwise, skip to D6.1.									
In the past 30 days, how much difficulty did your relative have in:									
D5.5	His or her day-to-day work/school?	None				or			
D5.6	Doing his or her most important work/school tasks well?	None				Extreme or		20	5
D5.7	Getting all of the work done that is needed?	None							
D5.8	Getting all the work done as quickly as needed?	None				or			
Participation in society									
Participation in society in the past 30 days:									
D6.1	How much of a problem did your relative have in joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None							
D6.2	How much of a problem did your relative have because of barriers or hindrances around him or her?	None							
D6.3	How much of a problem did your relative have living with dignity because of the attitudes and actions of others?	None						40	5
D6.4	How much time did your relative spend on his or her health condition or its consequences?	None				r			
D6.5	How much has your relative been emotionally affected by his or her health condition?	None							
D6.6	How much has his or her health been a drain on his or her financial resources or the financial resources of other relatives?	None							

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