Member Contact Information

Date:_____

PATIENT INFORMATION

Name (First, MI, Last)_____Social Security #_____

Address_____City_____State_____Zip_____

Date of Birth _____ Age_____ Male_____ Female_____ How Long Have You Lived Here?_____

Home Phone_____ May We Call You At Home? Yes_____ No_____

Work Phone_____ May We Call You At Work? Yes_____ No_____

Cell Phone _____ May We Call You On Your Cell? Yes_____ No _____

Email: _____ May we contact you by email? Yes _____ No _____

What Number Should We Use For Your Reminder Call? _____

Occupation_____ Employer/School_____

How Long at this Occupation? _____ How Long At This Present Job? _____ Highest Grade Completed _____

Birthplace_____ Religion_____ Military Service _____

Who referred You to Our Practice? _____

Who Should We Contact In Case Of An Emergency? Name_____ Phone _____

IF PATIENT IS A MINOR*:

Mother Name_____ Address_____

Employer_____ Occupation_____ Social Security #_____

Home Phone _____ Work Phone _____ Cell Phone_____

Date of Birth_____ Does Patient Live With This Parent? Yes_____ No_____

Father Name_____ Address_____

Employer_____ Occupation_____ Social Security #_____

Home Phone _____ Work Phone _____ Cell Phone_____

Date of Birth_____ Does Patient Live With This Parent? Yes_____ No_____

***If the patient is a minor, the parent or legal guardian whose name/signature appears in this paperwork is responsible for all charges after insurance.**

Insurance Information

Patients Primary Insurance Information: (We will need a copy of your Insurance Card)

Insurance Company Name _____ID #_____Group #_____

Subscriber's Name_____ Date of Birth_____ SSN_____

Address (if Different From Patient) _____City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Relationship to Insured (Circle One): Self/Spouse/Child/Other

Patient's Secondary Insurance Information: (We will need to copy your insurance card)

Insurance Company Name _____ID #_____Group #_____

Subscriber's Name_____ Date of Birth_____ SSN_____

Address (if Different From Patient) _____City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Relationship to Insured (Circle One): Self/Spouse/Child/Other

All **co-payments will be collected** at the time of service. **If you do not have insurance, payment is expected the time of service.**

It is up to you to provide us with all information necessary to bill your insurance company. We do not guarantee payment. You will be responsible for payment of all services not covered by your insurance company. We will not bill your insurance company if you are seeing an out-of-network provider; you will be responsible for payment at the time of service. We can however, provide you with an invoice which contains all the necessary information for you to submit a claim to your insurance company for reimbursement. If you know your deductible has not been satisfied for the year, please pay at the time of service. We will bill your insurance company t give you credit for the allowable amount toward your deductible. **WE HAVE A 24 HOUR CANCELLATION POLICY. IF YOU MUST CANCEL YOUR APPOINTMENT, PLEASE GIVE US 24 HOURS NOTICE. IF YOU CANCEL YOUR APPOINTMENT LATE OR DO NOT SHOW UP, YOU WILL BE CHARGED IN FULL FOR THE APPOINTMENT. YOUR INSURANCE COMPANY CANNOT BE BILLED FOR THE CHARGE.**

ACKNOWLEDGEMENT: I have read the above policy statement and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account in a timely manner. I agree that in the event that costs and/or fees are incurred in connection with collection of my account. I will pay all such costs and fees, including but not limited to collection costs, attorney fees and all court costs.

AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER: I hereby authorize payment to my insurance company directly to my individual provider or employees of Sanctuary: NTC. I also give Sanctuary: NTC permission to appeal any denied claims on my behalf.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Sanctuary: NTC, and/or my individual provider to release to my insurance company any and all information they may require concerning my care.

I am the guarantor for the following individual (and for whom I give Sanctuary: NTC or my individual provider permission to treat). **If the patient is a minor; I am the guarantor and accept responsibility for payment.**

_____ _____
Patient (Guarantor's Signature) Date

_____ _____
Guarantor's Signature for Minor Patient Date

_____ _____
Witness Date

Consent for Assessment and Treatment

This document/agreement contains important information about 1) our professional services, 2) our business practices.

Purpose and Mission of Sanctuary: Neuropsychology & Treatment Consultants

Our mission is to foster the success of our members and their families through innovative, evidence based treatment for people of all walks of life, resulting in recovery and improved resiliency. Members will participate in assessment and treatment which builds on the individual's strengths and can expect to be treated with both dignity and respect.

Sanctuary: Neuropsychology & Treatment Consultants will be recognized as a leader in clinical services, training, research, and advancing evidence based clinical treatment.

Neuropsychological & Psychological Services

Effective treatment depends upon the particular problems you are experiencing, as well as personality factors and establishing a good clinician-client alliance. Psychotherapy may call for more active disclosure and effort on your part. For therapy to be most successful, we recommend you work on the things we talk about during the session and at home. Psychological treatment includes potential for some risk as well as benefits. Since therapy involves discussing unpleasant aspects of your life, you may experience feelings, which may be temporarily uncomfortable. On the other hand, psychological treatment has been known to produce many benefits such as reduction in distress, solutions to specific problems, and better relationships. There can be no guarantees of what you will experience. Sanctuary: Neuropsychology & Treatment Consultants attempts to minimize risks by employing well-trained clinicians and by frequent conversations with you about your progress.

The first few sessions will involve evaluation of your needs. By the end of this evaluation period, your clinician will be able to offer you an initial impression of your needs and a plan for what treatment might include, if you decide to continue with therapy. If you ever have any questions about procedures, you should discuss them whenever they arise.

Sanctuary: Neuropsychology & Treatment Consultants' hours vary during the week. Sanctuary provides full time voice mail, but you may not be able to reach your clinician who may be out of the office or seeing other clients. Your clinician will make every effort to return your call as soon as possible. If you are difficult to reach, please inform your clinician of times you might be available. Sanctuary: Neuropsychology & Treatment Consultants does not currently provide emergency services (see Emergency Care and Crisis Situations).

Forensic (Legal) Services:

Sanctuary: Neuropsychology & Treatment Consultants provides a variety of forensic services including evaluations and court testimony. If you know you may need these services, please feel free to mention it at any point at the beginning or during services. We will be happy to provide what help we can. Importantly, presenting your clinician with an unexpected subpoena to testify or produce records for the courts rarely benefits you. Unfortunately, it is often interpreted by the legal system as deception or manipulation and typically damages the therapeutic relationship between you and your clinician.

Research & Training:

Sanctuary: Neuropsychology & Treatment Consultants has secondary goals of training the next generation of mental health professionals and advancing psychological science. To this end, we are affiliated with Idaho State University. While the confidentiality of every member receiving services through the clinic is strictly maintained, your case may be discussed within the confines of the clinic for training and quality service improvement purposes. Further, if you are participating in services, you may be asked if you are willing to have a session recorded. However, prior to this occurring, you will be asked to specifically sign a form consenting to recording.

In addition, at times, research opportunities may arise for a family or individual in your situation. When these occur, you may be contacted to see if the opportunity is of interest to you. Of note, unless you specifically request otherwise, if you participate in neuropsychological or psychological testing your anonymous data will be kept in our secure database for potential future research on individuals with your condition. To reiterate, in this situation your personal information will in no way be connected to your test data.

Emergency Care and Crisis Situations

Sanctuary: Neuropsychology & Treatment Consultants is not able to provide emergency services or psychiatric medications. Individuals who need emergency clinical access should contact 911 or access an emergency room or emergency provider such as the State of Idaho Department of Health and Welfare.

Fees, Billing, and Payment Policy

The fee for therapy sessions is listed as follows, but may be subject to change in special circumstances:

Psychiatric Diagnostic Assessment/Intake	$180.00 p/evaluation
Case Consultation - Family/Individual	$95.00 p/session*
Family/Individual Therapy	$95.00 p/session*
Group Therapy / Skills Training Class	$30.00 p/session*
Biofeedback/Neurofeedback	$37.50 p/unit**
Neuropsychological/Psychological Testing - & Report Writing	$105.00 p/hour
Forensic Services:	
Psychological/Neuropsychological	$150.00 p/session*
Expert Testimony	$150.00 p/session*
Therapy/skills training	$150.00 p/session*
Designated examination/Testimony	$150.00 p/session*
Competency Evaluation	$150.00 p/session*
Case Management	$15.00 p/unit**
Community Based Rehabilitative Services	$15.00 p/unit**

*Session (approximately 45 minutes – divisible/cumulative by 30 minute increments)
**Unit (approximately 15 minutes)

Individuals paying cash prior to the administration of services qualify for a 25% reduction in fees. Holiday or after hours (11pm-6am) work may require a modification or increase in fees not to exceed an additional 25% of fees as listed above.

Sanctuary: Neuropsychology & Treatment Consultants' clients must pay their co-pay amount at the time of service. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Sanctuary: Neuropsychology & Treatment Consultants has the option of using legal means to secure payment. This may involve contracting with a collection agency which requires us to disclose otherwise confidential information. In most collection situations, the only information Sanctuary: Neuropsychology & Treatment Consultants releases are the client's name, contact information, such as address, the nature of the services provided, and the amount due.

If you wish to apply for payment under a health insurance policy, Sanctuary: Neuropsychology & Treatment Consultants will work with your insurance company as long as your clinician is a contracted provider covered by your policy. It is very important that you understand what your insurance covers and does not cover. Sometimes prior authorization is required for mental health services or the services are limited to a specific number of sessions, certain types of therapy, or assessment services, or approved providers. Often court-ordered services are not covered by insurance companies. If necessary, call your plan administrator to have your questions answered. Ultimately, you (not your insurance company) are responsible for full payment of Sanctuary: Neuropsychology & Treatment Consultants' fees.

MEMBER'S RIGHTS AND RESPONSIBILITES

Member's Rights

Members have the right to:

- Receive information about services and member's rights and responsibilities.
- Be treated with respect and recognition of his/her dignity and right to privacy.
- Participate with practitioners in making decisions about his/her mental health care.
- A candid discussion of appropriate or medically necessary treatment options for his/her condition.
- Voice complaints or appeals about Sanctuary: Neuropsychology & Treatment Consultants for the services provided by Sanctuary: Neuropsychology & Treatment Consultants.
    - When concerns or complaints arise, a member can discuss it with any staff, volunteer, or student working for Sanctuary: Neuropsychology & Treatment Consultants, with whom they feel comfortable. The concern will try to be resolved informally

initially to the satisfaction of the member. If that is insufficient, the staff member can help the member participate in the formal grievance process.

- Make recommendations regarding Sanctuary: Neuropsychology & Treatment Consultants' members' rights and responsibilities policies.
- Care that is considerate and that respects his/her personal values and belief system.
- Personal privacy and confidentiality of information.
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Have family members participate in treatment planning. Members over 12-years-old have the right to participate in such planning
- Individualized treatment, including:
    - Adequate and humane services regardless of the source(s) of financial support.
    - Provision of services within the least restrictive environment possible.
    - An individualized treatment or program plan.
    - Periodic review of the treatment or program plan.
    - An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan.

- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
    - Resolving conflict.
    - Participating in research, investigational studies, or clinical trials.
    - Designate a surrogate decision-maker if he/she is incapable of understanding a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.
    - Be informed, along with his/her family, of his/her Sanctuary: Neuropsychology & Treatment Consultants rights in a language they understand.
    - Choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations.
    - Be informed of rules and regulations concerning his/her own conduct
    - Be informed of the reason for any non-coverage determination, including the specific criteria or benefits provisions used in the determination.

- Inspect and copy their protected health information (PHI) and in addition:
    - Request to amend their PHI.
    - Request an accounting of non-routine disclosures of PHI.
    - Request limitations on the use or disclosure of PHI.
    - Request confidential communications of PHI to be sent to an alternate address or by alternate means.
    - Make a complaint regarding use or disclosure of PHI.
    - Receive a Privacy Notice regarding their PHI.

Member Responsibilities:

Members have the responsibility to:

- Supply information (to the extent possible), that Sanctuary: Neuropsychology & Treatment Consultants' practitioners need in order to provide care.
- Follow plans and instructions for care that they have agreed on with his/her network practitioner.
- Understand his/her health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Keep scheduled appointments and actively participate in treatment.

Assessment Referral List

Speech Language Pathology

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Occupational Therapy

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Physical Therapy

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Hearing

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Current Developmental Disability Agencies in Southeast Idaho recognized by the

Idaho Department of Health and Welfare:

A New Hope

Access Point Family Services, Inc.

Adolescent and Child Development Center, LLC

Allies Family Solutions

Center Case Management and DD Services, LLC

Community Connections of Pocatello

Dawn Enterprises, Inc.

Franklin County Development Services

Grace Educational Opportunities, Inc.

Southeastern Idaho Developmental Center

Swift dba New Day Products and Resources, Inc.

Contact information for these agencies are available on request or by visiting the Idaho Department of Health and Welfare website. (Http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=sxQW30i645k%3d&tabid=398&mid=2068)

By signing below, I certify that I am aware of these agencies and choose to be a customer of Sanctuary: Neuropsychology & Treatment Consultants of my own volition.

Informed Consent

Your signature below indicates that you have read this agreement and agree to its terms.

These matters have been explained to you and you fully and freely give consent to receive Sanctuary: Neuropsychology & Treatment Consultants evaluation and/or treatment services.

_____

Name of Client(s) and/or minor child (please print)

_____ _____

Signature of Client(s) and/or minor child Date

_____ _____

Signature of Representative of Minor Patient Date

_____ _____

Sanctuary: NTC Clinician/Witness Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE

This notice of Privacy practices describes how Sanctuary: Neuropsychology & Treatment Consultants handles confidential information, following state and federal requirements. All programs in Sanctuary: Neuropsychology & Treatment Consultants may share your confidential information with each other as needed to provide you with benefits of services, and for normal business purposes. Sanctuary: Neuropsychology & Treatment Consultants may also share your confidential information with others outside of Sanctuary: Neuropsychology & Treatment Consultants as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from Sanctuary: Neuropsychology & Treatment Consultants. We need these records to give you quality of care and services. We also need these records to follow various local and federal laws.

We are required to:

- Use and disclose confidential information as required by law.
- Maintain the privacy of your information
- Give you this notice of our legal duties and privacy practices for your information, and
- Follow the terms of the notice that is currently in effect.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law, HIPAA, provides privacy protections for medical records and new client rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. This notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that Sanctuary: Neuropsychology & Treatment Consultants has provided you with this information at the end of this session.

Confidentiality

Federal and state law protects the privacy of communication between a client and a psychologist/clinician. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations, Sanctuary: Neuropsychology & Treatment Consultants will only release information about your treatment to others if you sign a written authorization that meets certain legal requirements. In the following situations, no authorization is required:

a) Clinical information about your case may be shared fully within Sanctuary: Neuropsychology & Treatment Consultants by the staff for the purposes of supervision were applicable.
b) Personal information is also shared for Sanctuary: Neuropsychology & Treatment Consultants' administrative purposes such as scheduling, billing, and quality assurance. Sanctuary: Neuropsychology & Treatment Consultants' files are also available to insurance company auditors. Data contained in your file are available for archival research (i.e., reviews of records to describe Sanctuary: Neuropsychology & Treatment Consultants' referrals, outcomes, and trends) as long as your identity cannot be linked to the data used. All staff members have been given training about protecting your privacy and have agreed not to disclose any information without authorization or approval of the Sanctuary: Neuropsychology & Treatment Consultants Clinic Director in mandated reporting situations (see Limits to Confidentiality).
c) On occasion Sanctuary: Neuropsychology & Treatment Consultants may find it helpful to consult with another health or mental health professional. During such a consultation, every effort is made to avoid revealing the identity of the client. If you do not object, it is our policy to tell you about such consultations only if it is important to you and your clinician working together. All consultations are noted in the client's records.
d) Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

e) Sanctuary requests permission to take your photograph for identification purposes only. This picture will not be shared with anyone._____(initials)

Consultation

For your information, the clinical providers of Sanctuary: Neuropsychology & Treatment Consultants function as a team and routinely consult regarding each member's case in order to provide the most effective and comprehensive care possible. In addition, some providers may consult with supervisors or other professionals outside of this clinic. In these situations, all professionals involved are bound by the confidentiality policies outlined in this document and have been required to sign a confidentiality agreement if they have access to the personal health information of a member.

Emails Cell phones Computers, & Faxes

It is important to be aware that computers and un-encrypted emails, texts, and faxed communications can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy/confidentiality of the information contained therein. Emails, texts, and faxes are vulnerable in that server/communication companies have access to the information sent through them. Further, they can be accidentally sent to an incorrect address or computer.

To combat these risks, the computers of Sanctuary: Neuropsychology & Treatment Consultants are equipped with firewalls, virus protection, and passwords. Further all information is routinely "backed-up" on encrypted hard-drives. Sanctuary: Neuropsychology & Treatment Consultants will not utilize emails, texts, or faxes without your direction to do so. Please notify the staff of Sanctuary: Neuropsychology & Treatment Consultants if you would like to specifically avoid or limit the use of emails, texts, cell phone calls, phone messages, or faxes when conveying your personal health information. If you communicate confidential or private information via un-encrypted e-mail, text, fax, or phone message, Sanctuary: Neuropsychology & Treatment Consultants will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate with those modalities. Please do not use texts, emails, voicemail, or faxes for emergencies.

Limits to Confidentiality

There are situations where Sanctuary: Neuropsychology & Treatment Consultants may be required or permitted to disclose information without your authorization. These situations are unusual at Sanctuary: Neuropsychology & Treatment Consultants, but include:

a) If Sanctuary has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a child, elderly person, or disabled person, it is required to file a report with the appropriate agency, usually the Department of Health and Human Services. Once such a report is filed, we may be required to provide additional information.
b) If a client communicates an explicit threat of serious physical harm and has the apparent intent and ability to carry out such a threat, Sanctuary: Neuropsychology & Treatment Consultants may be required to take protective actions. These actions may include contacting the police and/or seeking hospitalization for the client.
c) If we believe that there is an imminent or even, in our judgment, high risk that the client will physically harm himself or herself, we will also take protective actions.
d) Although courts have recognized clinician-client confidentiality, there may be circumstances in which a court would order Sanctuary: Neuropsychology & Treatment Consultants to disclose personal health or treatment information. We also may be required to provide information about court ordered evaluations or treatments. If you are involved in, or contemplating litigation, you could consult with an attorney to determine whether a court would be likely to order Sanctuary: Neuropsychology & Treatment Consultants to disclose information.
e) Sanctuary: Neuropsychology & Treatment Consultants is required to provide information to a legal guardian of a minor child, including a non-custodial parent.
f) If a government agency is requesting information for health oversight activities or to prevent terrorism (patriot Act), Sanctuary: Neuropsychology & Treatment Consultants may be required to provide it.
g) If a client files a worker's compensation case, Sanctuary: Neuropsychology & Treatment Consultants may be required, upon appropriate request, to provide all clinical information relevant or bearing upon the injury for which the claim was filed.
h) If a client files a complaint or lawsuit against Sanctuary: Neuropsychology & Treatment Consultants or professional staff, Sanctuary: Neuropsychology & Treatment Consultants may disclose relevant information regarding the client in order to defend itself.

If any of these situations were to arise, Sanctuary: Neuropsychology & Treatment Consultants would make every effort to fully discuss it with you before taking action, and would limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you have with us now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Professional Records and Clients Rights

The laws and standards of the mental health profession require that Sanctuary: Neuropsychology & Treatment Consultants keep Protected Health Information (PHI) about you in your clinical record. Generally, you may examine and/or receive a copy of your clinical record, if you request it in writing. There are a few exceptions to this access: 1) some of the unusual circumstances described above, 2) when the record makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause substantial harm to that other person or 3) where information has been supplied confidentially by others. Also, the clinic will not release copyrighted test information or raw data. Because these are professional records, they can be misinterpreted. For this reason, Sanctuary: Neuropsychology & Treatment Consultants recommends that you initially review them in the presence of your clinician, or have them forwarded to another mental health professional so you can discuss the contents. Sanctuary: Neuropsychology & Treatment Consultants keeps no additional notes (sometimes called psychotherapy or process notes) beyond that which is in the clinical record. In most circumstances, Sanctuary: Neuropsychology & Treatment Consultants is allowed to charge a copying fee for re-producing your records. If Sanctuary: Neuropsychology & Treatment Consultants refuses your request for access to your records, you have the right of a review of this decision (except for information supplied confidentially by others), which the Sanctuary: Neuropsychology & Treatment Consultants Clinic Director will discuss with you upon request.

Minors and Parents

Please be informed that according to state and federal law, any person with legal rights pertaining to a child (e.g., legal guardian or non-custodial parent) may have the legal right to terminate the child's services unless that person has given his/her signed, informed consent. As stated earlier, Sanctuary: Neuropsychology & Treatment Consultants will honor requests for information by a legal guardian of a minor child.

Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents to examine their clinical records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is Sanctuary: Neuropsychology & Treatment Consultants prerogative to request an agreement from parents that they consent to give up access to their child's records. If the parent's agree, Sanctuary: Neuropsychology & Treatment Consultants will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Parents may be provided a summary of their child's treatment when it is complete. Other communications will require the teenagers assent, unless Sanctuary: Neuropsychology & Treatment Consultants feels it is a crisis situation including personal risk or physical danger to the minor. If possible, such disclosures would be discussed beforehand with the teenager to minimize his/her objections and concerns.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. **Right to Review and Copy**
   You have the right to ask to review and copy your information as allowed by law.

   If you would like to ask to review and copy your information a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

   If you ask to receive a copy of the information, we may charge a fee. If you request 100 pages or more from our files, the fee will be 25 cents per page.

   You will be told if there is information we are legally prevented from disclosing to you.

2. **Right to Amend**
   You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask Sanctuary: NTC to change your information a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to the Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

We may deny your request if you ask us to change information that:

- Was not created by Sanctuary: Neuropsychology & Treatment Consultants
- Is not part of the information kept by or for Sanctuary: Neuropsychology & Treatment Consultants
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. **Right to Restrict Health Information Disclosures**

You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask Sanctuary: Neuropsychology & Treatment Consultants to not share your information, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction.

4. **Right to an Alternate Means of Delivery**

You have the right to ask that we deliver your information to you at a different mailing address. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery of your information, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

Reasonable requests will be approved.

5. **Right to a Report of Health Information Disclosures**

You have the right to ask for a report of the disclosures of your health information. This report for disclosures will not include when we have shared your health information for treatment, payment for your treatment, or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs for providing the report. We will tell you the cost and you may choose to remove or change your request at the time before any costs are charged to you.

I acknowledge that I received my Sanctuary: Neuropsychology & Treatment Consultants' privacy practices form on _____, by my signature below.

_____
Name of Client(s) and/or minor child (please print)

_____ _____
Signature of Client(s) and/or minor child Date

_____ _____
Signature of Representative of Minor Patient Date

_____ _____
Sanctuary: NTC Clinician/Witness Date

AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

Sanctuary counseling and psychological testing

Phone: 208-417-0623; Fax: 208-417-0641

Date:_____

PATIENT NAME:_____ DOB:_____

A. Mental Health/Other Service Provider:_____
   Contact Name: Phone :_____

   Address: Fax:_____

B. Medical/Primary Care:_____
   Physician Name: _____Phone :_____

   Address: Fax:_____

Please initail each category of specific information that you are allowing to be released or exhanged. Write 'No' in categories of information that you are not allowing to be released.

_____Verification of services received _____Dates of treatment

_____6 MonthTreatment Summary _____Letter(s) of support

_____6 Month Medication history and medication record _____Oral communication as needed

_____Psychiatric and psychological counseling record _____Psychological testing results

_____Psychological and/or psycho-diagnositc assessment _____Plan of service/evaluation

The information is being released or exchanged for the following purpose(s):

Coordination of treatment Family consultation Other _____

I decline giving Sanctuary Counseling my medical information

Printed Name of Client/Patient_____ Self Parent/Guardian

Signature of Client/Patient_____

This release expires a year from today's date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protested by fedreal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclousre of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or oterh information is not sufficient for this purpose.

Sanctuary counseling and psychological testing

Psychological & Medical History

Part I: Demographic Information

Name: _____ Date of Birth: _____ Social Security Number: _____

Today's Date: _____ Age: _____ Gender: _____ Race/Ethnicity: _____

Social Support (where applicable) **Is the relationship good, bad, or other?**

Spouse/Significant Other Name: _____ _____

Former Spouse's/Significant Other's Names: _____ _____

Children's Names & Ages: _____ _____

_____ _____

Mother's Name: _____ _____

Father's Name: _____ _____

Step-Mother's Name: _____ _____

Step-Father's Name: _____ _____

Siblings Names & Ages: _____ _____

_____ _____

Treatment Providers **Do you want us to coordinate care with this professional?** **Contact information?**

Medical Provider: _____ YES / NO _____

Psychiatric Medication Provider: _____ YES / NO _____

Psychotherapist/Counselor: _____ YES / NO _____

Other: _____ YES / NO _____

Part II: Reason for Referral

Please describe the primary reason for seeking assistance at this time:

_____

_____

Part III: Current & Past Treatment:

Have you participated in treatment for any of these problems?

Counseling/psychotherapy: When? _____ With whom? _____ Was it helpful? _____

_____ _____ _____

Hospitalization: When? _____ Where? _____ Was it helpful? _____

Other Treatment (Please describe):_____

_____

Previous Psychological/Neuropsychological Testing: _____

_____

_____

Medications:
Current:

Type & Dosage? _____	When?_____	Is it helpful?_____
Type & Dosage? _____	When?_____	Is it helpful?_____
Type & Dosage? _____	When?_____	Is it helpful?_____
Type & Dosage? _____	When?_____	Is it helpful?_____

Past:
Helpful Medications: _____

Ineffective Medications: _____

Part IV: Symptom Screening:

Please indicate the following **symptoms** or **problems** you have experienced now or in the past, **when they first occurred**, and also describe **how long** they were or have been present:

Symptom/Problem:	What age did it start?	Is it a (C) Current or (P) Past problem? How long did it last?	Did/does a family member have this problem? Who?
Mental Health Symptoms:			
Anxiety			
Depression			
Rapid Mood Changes			
High Levels of Stress			
Panic Attacks			
Chronic Worry			
Relationship Problems			
Suicidal Thoughts			
Trauma			
Drug Problems			
Alcohol Problems			
Chronic Anger			
Grief			
Visual Hallucinations			
Auditory Hallucinations (voices)			
Chronic Irritability			
Sexual Problems			
Sleep Problems			
Intrusive Thoughts			
Obsessive Thoughts			
Paranoia			
Thoughts of Harming Others			
Other:			
Other:			
Behavior Problems:			
Self-Injurious Behavior			
Suicide Attempts			
Impulsivity			
Hyperactivity			
Fighting			
Destruction of Property			
Deception			
Theft			
Pornography			

Verbal Aggression			
Socially Inappropriate			
Problems Making Friends			
Property Destruction:			
Threatening Behavior:			
Other:			
Other:			
Cognitive Problems:			
Attention Problems			
Short-term memory problems			
Long-term memory problems			
Poor Judgement			
Racing Thoughts			
Reading Problems			
Spelling/Writing Problems			
Learning Problems			
Migraines			
Concussions			
Loss of Consciousness			
Stroke			
Black-outs			
Seizures			
Head Injuries			
Other:			
Other:			
Developmental Problems:			
Prenatal Exposure to Alcohol:			
Prenatal Exposure to Drugs:			
Prenatal Exposure to Accutane:			
Parental Exposure to Chemicals:			
Prenatal Medical Problems:			
Birth Complications:			
Serious Newborn Illnesses:			
Late Walking:			
Late Talking:			
Speech & Language Problems:			
Problems Making Eye Contact:			
Overly Sensitive to Sound:			
Overly Sensitive to Textures:			
Poor Sensitivity to Sound:			
Poor Sensitivity to Pain:			
Late Reading:			
Late Toileting:			
Toileting Problems:			
Late Developing Humor:			
Unusual Sense of Humor:			
Overly Literal:			
Late Understanding Sarcasm:			
Late Social Development:			
Late Cognitive Abilities:			
Other:			
Other:			

Patient Health Questionnaire – PHQ-9

Name:_____ Date:_____

Over the last two weeks, how often have you been bothered by any of the following problems? Please circle one for each question.				
Little interest of pleasure in doing things?	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless?	Not at all	Several days	More than half the days	Nearly every day
Trouble falling or staying asleep, or sleeping too much?	Not at all	Several days	More than half the days	Nearly every day
Feeling tired or having little energy?	Not at all	Several days	More than half the days	Nearly every day
Poor appetite or overeating?	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	Not at all	Several days	More than half the days	Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television?	Not at all	Several days	More than half the days	Nearly every day
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	Not at all	Several days	More than half the days	Nearly every day
Thoughts that you would be better off dead, or of hurting yourself in some way?	Not at all	Several days	More than half the days	Nearly every day
Total= /27				
Depression Severity: 0-4 none; 5-9 mild; 10-14 moderate; 15-19 severe; 20-27 severe				

PTSD Checklist – Civilian Version (PCL-C)

Client Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the last month.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2	Repeated, disturbing dreams of a stressful experience from the past?					
3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
4	Feeling very upset when something reminded you of a stressful experience from the past?					
5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?					
6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
7	Avoid activities or situations because they remind you of a stressful experience from the past?					
8	Trouble remembering important parts of a stressful experience from the past?					
9	Loss of interest in things that you used to enjoy?					
10	Feeling distant or cut off from other people?					
11	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12	Feeling as if your future will somehow be cut short?					
13	Trouble falling or staying asleep?					
14	Feeling irritable or having angry outburst?					
15	Having difficulty concentrating?					
16	Being "super alert" or watchful on guard?					
17	Feeling jumpy or easily startled?					