ANDREA JULIA VIEGAS, Ph.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist

608 Davis Circle
Huntsville AL 35801
Phone: 256-533-5792
Fax: 256-533-0024

****Please follow the directions provided by Office Staff**

WELCOME

Thank you for completing the attached forms. I would like this to be a comfortable experience for you. Please feel free to ask questions or express concerns at your Initial session.

****If coming for an evaluation of memory functioning please have a family member or individual accompany you who can provide further information.***

OFFICE HOURS

My business hours at 608 Davis Circle, Huntsville are Monday, Tuesday, Wednesday, and Thursday from 8:00am to 5:00pm. All sessions and testing are by appointment only. Please feel free to call me at 256-533-5792. If I am in session, I will attempt to return your call at my earliest. If you have an emergency and are unable to reach me, please call the helpline or go to the closest emergency room.

APPOINTMENTS

Therapy sessions are 45-50 minutes in duration. Testing and assessment hours are variable. All testing and therapy session have an Initial Clinical Diagnostic session with follow-up testing or therapy session. To change or cancel an appointment for therapy please call the office 48 working hours. For neuropsychological/psychological testing please call 72 working hours. This will avoid you being charged for time reserved for you. Emergency cancellation will require a certificate either medical or legal stating such.

BILLING AND PAYMENTS

We will file your insurance as a courtesy. Please be aware that you (not your insurance company) are responsible for full payments and fees. It is very important that you be aware of your medical benefits from your insurance company especially for testing. Insurance companies do not cover "no shows" and late cancellation of appointments and you will be responsible for this. Please be aware that we keep the 5-6 hours for psychological/neuropsychological testing only for you and no shows and late cancellation without medical/legal emergency letter will be billed to you.

All late payments carry a monthly penalty charge.
***My billing company is* Millennium Medical Billing and Physician Services Inc.**
Tel: 256-532-1888 and Fax 256-532-3941 *– All information is held very confidential with them.*

ANDREA J. VIEGAS, Ph.D.
608 Davis Circle, Huntsville AL 35801
(PH) 256:533:5792 (FAX) 256-533-0024

Please complete the following confidential information **Please bring your drivers license & Insurance card(s) with you.**

FULL NAME: _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SS #:**_____

PRESENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MARITAL STATUS: _____ **SEX: MALE FEMALE**

NAME OF EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS OF EMPLOYER: _____

Phone numbers where you can be contacted and we have your permission to leave a message:

HOME: _____ **OFFICE:** _____ **CELL:** _____

NAME OF SPOUSE / PARENT / OTHER: _____
OCCUPATION: _____ **phone #:** _____

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Name of Insurance Co:	Name of Insurance Co.
POLICY #:	**POLICY #:**
GROUP #:	**GROUP #:**
SUBSCRIBER NAME:	**SUBSCRIBER NAME:**
SUBSCRIBER Date of Birth:	**SUBSCRIBER Date of Birth:**
EMPLOYER:	**EMPLOYER:**
EFFECTIVE DATE:	**EFFECTIVE DATE:**

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT:

NAME : _____ **SOCIAL SECURITY #:** _____

ADDRESS: _____ **DATE OF BIRTH:** _____
_____ **Phone #:** _____

Please turn over…….

In the event of an emergency please provide name and phone number of a person that we have your permission to contact:

NAME: _____ **PHONE #:** _____

Relationship: _____ **ADDRESS:** _____

Dr. Viegas is completely independent in providing clinical services and alone will be responsible for those services. Her professional records are separately maintained and no member of the group can have access to them without specific written permission from you.

AUTHORIZATION AND ASSIGNMENT:

By my signature below, I directly assign all insurance benefits relating to the services provided to Dr. Andrea J. Viegas, Ph.D. I understand that I am financially responsible for all charges not covered by my insurance. I understand that if Dr. Viegas is not an in-network provider for my insurance company, I am responsible for payments in full at the time of service. Insurance co-pays and deductibles are due at the time of service. I further agree that a photocopy of this agreement shall be as valid as the original.

In the event of non-payments either by my insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provisions of this contract. I/We further agree to waive all my/our rights of exemption under the laws of the State of Alabama or of any other state.

TO BE SIGNED BY PATIENT OR GUARDIAN:

All information I have provided is accurate especially pertaining to my insurance. Should my benefits or Insurance change, it is my responsibility to contact Dr. Viegas or her staff.

X_____ _____ _____

PRINT NAME **SIGNATURE** **DATE:**

HIPAA Authorization for Disclosure of Information

I have read and/or am familiar with the HIPAA Notice of Policies and Practices to Protect your Health Information. A copy has been made available to me if desired.

X_____ _____ _____

PRINT NAME: **Signature:** **Date**

608 Davis Circle, S.W.
Huntsville, AL 35801

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PATIENT / RESPONSIBLE PARTY FINANCIAL AGREEMENT
PLEASE TAKE A MOMENT TO READ CAREFULLY

This covers Initial, Therapy sessions and psychological / neuropsychological evaluation
It is your responsibility to check with your insurance company regarding your benefits and deductible amount. Please read your INSURANCE HANDBOOK

1. The fees charged are compatible to those charged in our community for professional Therapy and Neuropsychological services

** **Initial Diagnostic session** ……. **CPT 90791** …….scheduled for 50 minutes.
** **Therapy sessions** ……**CPT 90837** …… scheduled for 45-50 minutes
** **Neuropsychological & Psychological testing: CPT code 96136 / 96137/ 96132 / 96133**

2. We will attempt to get authorization from your insurance company. Many insurance companies no longer provide Authorization. Therefore should they not cover the therapy session, or testing this will be your financial responsibility.
If your deductible is not met at the time of the session you will be responsible for the visit.

Co-payment & other charges are required at the time of visit [cash and check only please]

3. **NO SHOWS OR CANCELLATION LESS THAN 36 HOURS (for THERAPY)**
and
72 hours FOR NEUROPSYCHOLOGICAL/PSYCHOLOGICAL TESTING
will be charged the amount of the visit
Multiple cancellations will result in termination as we keep this hour only for you.
[Saturday and Sunday, and holidays and after the office is closed are not working hours !]

Signed: _____

4. "*I understand that billing my insurance company is a courtesy service provided by Dr. Viegas. If my insurance company does not cover this visit, or future sessions, I understand that I am financially responsible. I understand that Authorization from my insurance company is not a guarantee of payment. [Pls read page 2 for exclusion criteria]*

Signed: _____

3. Returned check will be charged $35.00 per check plus the amount of the original check. All collection charges will be billed to the patient

Signed: _____

I have read and understand the above. If patient is a minor, this is to be read and signed by the parent/guardian." If the patient is not mentally competent to sign this form at this time a family member should sign. "By signing this form I am capable and of sound mind and judgment at this time."

_____ _____

Signature & Name of Insured/Responsible Party/Parent/Guardian Date

_____ _____

Witness Signature Date

SOME POSSIBLE REASONS WHY YOUR INSURANCE COMPANY MAY REJECT CLAIMS - THIS IS YOUR FINANCIAL RESPONSIBILITY

1. If you have visited a medical professional utilizing the same CPT billing code in the past three months (check with your insurance company the time factor).
2. If you have a deductible that is not met for the year.
3. Insurance benefits are maximized for the year.
4. If Blue Cross Blue Shield is your primary insurance company and you have maximized your visits for the year your secondary insurance company will not pay. *****
5. Insurance benefits are terminated due to job termination or changes in benefit plan.
6. Academic testing / testing for learning disability /ADD-ADHD testing is not covered by most insurance companies.
7. Should you see a psychiatrist on the same day you see a psychologist – most insurance companies will only pay one of the professionals for the visit.
8. Please be aware that many insurance companies will only pay for one neuropsychological / psychological evaluation per year or lifetime. If you have had a prior neuropsychological /psychological evaluation - please check with your insurance company as to their policy.
9. Please be advised that you are responsible to see that the provider you have chosen is on your preferred provider list and is in-network.
10. If you are visiting other mental health providers your insurance company may only pay a limited amount of visits or may decide to cover only one provider.
11. Preexisting conditions may not be covered by your insurance company.
12. If you have changed your insurance company and not informed our office.

Please <u>read</u> your insurance handbook carefully to see what is allowed/covered or not allowed/or not covered.

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BRIEF HISTORY QUESTIONNAIRE FOR ADULTS

(21 YRS & ABOVE)

This questionnaire covers health and developmental history items, which are important parts of new patient evaluations. The information you provide will help me provide you with the very best care possible. This form will become part of your clinical record, and as such, your responses will be held in confidence to the degree specified by law. It should take about 20 minutes to fill out the questionnaire completely.

PLEASE FILL THE FORM COMPLETELY

**** If you are referred for evaluation of memory functioning please bring a family member or ADULT individual who can provide relevant medical history****

GENERAL INFORMATION

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: M F

PLACE OF BIRTH: _____

PRESENT OCCUPATION: _____

MARITAL STATUS : _____ LENGTH OF MARRIAGE: _____

If married: AGE OF SPOUSE: _____ SPOUSE'S OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU: _____

Please specify if you are here for:

THERAPY OR PSYCHOLOGICAL / NEUROPSYCHOLOGICAL EVALUATION

PLEASE DESCRIBE IN DETAIL THE MAIN PROBLEM OR CONDITION FOR WHICH YOU ARE CURRENTLY SEEKING HELP : ** PLEASE SPECIFY SYMPTOMS **** :**

_____

_____

_____

_____

When were these symptoms first observed (age) _____ (approximate year) _____

Describe how you have been feeling the past two years (symptoms):

.Past year: _____

2 years prior: _____

EDUCATIONAL / OCCUPATIONAL INFORMATION

Please indicate your highest educational level completed:

_____ Middle School
_____ GED GED **Year:** _____
_____ **High School** **Year of Graduation:** _____ **Name of School:** _____
_____ Trade School **Year:** _____
_____ Some College
_____ College Graduate …….. **Year graduated:** _____
_____ Graduate / Professional School **Year graduated:** _____

Name of University	**Location**	**Dates Attended**
College/Univ:_____	_____	_____
Degree in:_____		
Postgraduate:_____	_____	_____
Degree in _____		

OCCUPATION

EMPLOYMENT: CURRENT AND PAST companies worked in **Dates**

Current : _____ _____

Past: 1. _____ _____

2. _____ _____

If extensive work history please bring in a CV or resume.

LEGAL HISTORY

Are you currently, or have you previously been involved in any civil or criminal legal proceedings ? If so, please provide details: _____

Is this assessment /neuropsychological evaluation / psychological assessment to be utilized in any way for LEGAL PURPOSES: (SPECIFY) _____

(1) Disability Determination : YES / NO Specify (Purpose): _____

(2) Military Disability Determination: YES / NO Specify (Purpose): _____

(2) Custody Hearing YES / NO Specify: _____
Alimony/ Child payment/ Divorce

(3) Workers Compensation YES / NO Specify: _____
(4) OTHER: Specify: _____

***Have you ever undergone/completed psychological and/or Neuropsychological Evaluation:
YES / NO
Who administered the Evaluation: _____
Address: _____ Dates: _____

MEDICAL HISTORY [please do not include psychiatric information]

Medical Diagnoses:	Date Diagnosed
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HOSPITALIZATIONS – Inpatient & Outpatient surgeries & hospitalizations

HOSPITAL	PURPOSE	DATES
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE INCLUDE ONLY CURRENT MEDICATION FOR MEDICAL DIAGNOSIS (Not Psychiatric medications)

Present Medication Name	Daily Dosage (mg)	When Prescribed (year)	Length of use	Medication helpful (yes/somewhat/no)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PSYCHIATRIC HISTORY

PSYCHIATRIC HOSPITALIZATIONS:

HOSPITAL	PURPOSE	DATES FROM --- TO
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ONLY CURRENT PSYCHIATRIC MEDICATIONS:

Psychiatric Medication Name	Daily Dosage (mg)	When Prescribed (year)	Length of use	Medication helpful (yes/somewhat/no)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Describe your current state of general health (circle one) POOR FAIR GOOD EXCELLENT

What is your approximate weight now? _____ 3 months ago? _____ 1 year ago? _____

Have you every had an allergy or reaction to any drug or medicine:

Drug	Reaction	Date
_____	_____	_____
_____	_____	_____

Please mark any of the following that pertains to your CURRENT lifestyle habits:

Habit	Yes/No	Average number per day
. cigarettes	_____	_____
. cigars	_____	_____
. Vaping	_____	_____
. pipe	_____	_____
. chewing tobacco/snuff	_____	_____
. coffee (8 oz)	_____	_____
. tea (8 oz)	_____	_____
. caffeinated soft drinks (12 oz)	_____	_____
. alcohol	_____	_____

Have you ever used alcohol or drugs (e.g. marijuana, cocaine) to help cope with your current conditions:

Alcohol: **Present use on average per day: _____ per week _____**

Past use on average per day: _____ per week _____

Drug: Present USE YES / NO

What are you presently using _____ _____

FAMILY INFORMATION

YOUR CHILDREN	AGE	BROTHERS/SISTERS	AGE

MOTHER: Age : _____ (Living /Deceased) Occupation:_____

Medical History:_____

FATHER: Age: _____ (Living / Deceased) Occupation: _____

Medical History: _____

MEDICAL/PSYCHIATRIC DIAGNOSES: * SPECIFY ONLY IF DIAGNOSED BY A PHYSICIAN:**

	Self	Mother	Father	Siblings	Children	Grandparent	Other
STROKE	___	_____	_____	_____	_____	_____	_____
TIA	___	_____	_____	_____	_____	_____	_____
DEMENTIA	___	_____	_____	_____	_____	_____	_____
CANCER [ ]	___	_____	_____	_____	_____	_____	_____
HEART ATTACK	___	_____	_____	_____	_____	_____	_____
Congestive Heart Failure	___	_____	_____	_____	_____	_____	_____
Heart Bypass # _____	___	_____	_____	_____	_____	_____	_____
Arthritis	___	_____	_____	_____	_____	_____	_____
High Blood Pressure	___	_____	_____	_____	_____	_____	_____
Cholesterol	___	_____	_____	_____	_____	_____	_____
Seizures	___	_____	_____	_____	_____	_____	_____
Parkinson's Disease	___	_____	_____	_____	_____	_____	_____
Diabetes	___	_____	_____	_____	_____	_____	_____
Thyroid Disease	___	_____	_____	_____	_____	_____	_____
Involuntary Movements	___	_____	_____	_____	_____	_____	_____
Tics	___	_____	_____	_____	_____	_____	_____
Suicide Attempts	___	_____	_____	_____	_____	_____	_____
Depression	___	_____	_____	_____	_____	_____	_____
Panic Disorder	___	_____	_____	_____	_____	_____	_____
Alcoholism	___	_____	_____	_____	_____	_____	_____
Drug Abuse	___	_____	_____	_____	_____	_____	_____
Obsessive-Compulsive	___	_____	_____	_____	_____	_____	_____
Schizophrenia	___	_____	_____	_____	_____	_____	_____
Manic Depressive	___	_____	_____	_____	_____	_____	_____
Anxiety	___	_____	_____	_____	_____	_____	_____
Attention Deficit disorder	___	_____	_____	_____	_____	_____	_____

PLEASE ADD ANYTHING NOT COVERED IN THIS QUESTIONNAIRE THAT YOU FEEL COULD HELP ME UNDERSTAND YOUR PROBLEM.

_____

_____

_____

NAME AND ADDRESSES OF DOCTORS AND MEDICAL PROFESSIONS INVOLVED IN YOUR CARE

NAME OF PHYSICIAN **PURPOSE:**

1. _____ _____

ADDRESS: _____

2. _____ _____

ADDRESS: _____

3. _____ _____

ADDRESS: _____

RELIGIOUS INFORMATION

Current Religion: _____ Religion in which you were raised:_____

Do you presently engage in any religious activity? YES NO

MILITARY HISTORY

Have you served in the armed forces ? YES NO If so, branch of service ?_____

Years: from_____ to _____ Rank start _____

How did you adjust to military life ? _____ Rank end: _____