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

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

New patients: Please arrive 15 minutes prior to appointment

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 bring a family member or individual who can provide additional 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

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 is responsible for those services. Dr. Viegas' 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 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.

__________________ ______________________________ ______________________

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.

________________________ ________________________________ ______________________

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

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

Andrea J. Viegas, Ph.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist

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

This covers all 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

. The Initial Diagnostic session are coded as **CPT 90791** and scheduled for 55 minutes.
. Therapy sessions are coded as **CPT 90837**
. 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 48 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 read your insurance handbook carefully to see what is allowed/covered or not allowed/or not covered.

<u>Form to be used till age 21.</u>	**Name:** ______________________________

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IDENTIFYING INFORMATION OF INDIVIDUAL

Please accompany your child or young adult to the initial clinical diagnostic evaluation.

CHILD'S FULL NAME: ____
**First		Middle		Last**

Birthdate: ______________________ **AGE:** _________ **SEX: Male** _____ **Female** _____

SCHOOL Currently Attending : ____

Address: __________________________________ **Grade:** ________ **Teacher:** ________

NAME OF PERSON FILLING OUT THIS FORM: ________________________________

RELATIONSHIP TO CHILD: ______________________________

REFERRED TO THE OFFICE BY: ____

PURPOSE OF VISIT:

THERAPY ____________		**PSYCHOLOGICAL TESTING** ____________

PLEASE DESCRIBE THE PROBLEMS YOU ARE CONCERNED WITH - PLEASE SPECIFY

____

____

____

____

1. PLEASE describe behavioral concerns......

____

____

____

____

Phone # where we can leave a message for appointments etc. Phone: ______________

______________________	____________	______________________
Emergency Contact	**Relationship**	**Additional Phone**

How is your child performing academically?

____

____

____

FAMILY INFORMATION:

Mother's Name:___________________________________ Age:_______ Education:______________

Place of Employment:____ Phone:____________________

Father's Name:_____________________________________ Age:_______ Education:______________

Place of Employment:____ Phone:____________________

Child's Legal Guardian:
__Both Natural Parents
__Natural Mother
__Natural Father
__Adoptive Parents
__Department of Human Resources
__Other (please explain)

Marital Status of Natural Parents
__Not Married
__Married
__Separated year__________
__Divorced year __________
__Father Remarried
__Mother Remarried

Who is currently living in the house with the child/adolescent: _______________________________________

____

Brothers and Sisters: (Please include and indicate half-brothers/sisters).

Name	Age	Learning / Medical / Psychiatric Problems

Handedness: Is your child right hand dominant or left hand dominant (circle)

- **Is your child in any special education classes?** ______________________________
- **Is your child on an Individual Education Plan or 504 Plan ?**

  Please Explain: ____

  Date when first on IEP: _______________ Grade: _______________

- **What is his/her best subject?**_____________ **worst subject?**______________
- **Does he/she (check all that apply)**

  __**Have speech problems** __**Use crutches/wheelchair/walker**

  __**Have a hearing aide** __**other (explain)**______________________

  __**Wear glasses**

- **Does your child have a medical diagnosis? If so, what is the diagnosis, who made it, and when was it made?**

Diagnosis: 1.______________________________ **2.** ______________________________

3. ______________________________ **4.** ______________________________

7. What medications, if any, does he/she take? What are the medications for?

Medication:______________________________ Dosage: __________Purpose: ________________________

Medication: ______________________________ Dosage: _________ Purpose: ________________________

Pediatrician / Primary Care Physician: (Name): ____

Address: ____ Phone #: ____________________________

Other doctors:

Name: ____ Address: ___________________________________

Has your child seen a psychologist, counselor, therapist, psychiatrist in the past. YES /NO

1. IF YES please provide details Name of the Professional : ______________________________

Date seen: from: ________ to _________ PURPOSE: ____________________________________

2. Professional: ____

Date seen: from: _______________ to _________ PURPOSE: ______________________________________

. Has he/she ever had any Psychological or School Testing (IQ) before? If so, when (month and year) and what was done? (Please include findings if you have them): If you are unsure please let Dr. Viegas know.

Date Child Tested: ______________________ Findings ___________________________________

Child was tested at : (Name & Address of hospital) ____

DEVELOPMENTAL HISTORY:

NAME OF THE HOSPTIAL **(where child was born)** _________________________________

PLACE (city & State)____

Birth Weight: ______________ **lbs** _____________ **ozs.**

Describe the Pregnancy : Illnesses: 1st Trimester : ______________________________
2nd Trimester: ______________________________
3rd Trimester: _______________________________

Medications: _______________________ ___________________________________ _________________________

Were you hospitalized during your pregnancy (prior to labor) : ____

Labor: Easy _____ **difficult:** ____________ **Describe:** ____

Vaginal ______________**or C-Section:** ________________________

Any problems experienced during delivery : ____

Newborn nursery: _____ **Well-baby neonatal nursery** _____ **High risk nursery** _____
How long did baby stay in nursery? ____
Difficulties in nursery, explain: ____

Was there any use of: ALCOHOL [YES / NO] DRUGS[YES / NO] CIGARETTE [YES / NO]during the pregnancy.

EARLY YEARS

1. Describe the **first three months :** Easy to care ______ Colicky : ____

   sleeping pattern: ___________________________ Feeding pattern: _________________________________

   Major Illnesses [first three months] : ____

2. Describe the **first year :** Easy to care ______ Difficult to care ____

   sleeping pattern: ___________________________ Eating pattern: ________________________________

   Major Illnesses [first year] : ____

3. Describe the **2nd year :** Easy to care _____________________ Difficult to care ________________
   sleeping pattern: ___________________________ Eating pattern: ________________________________

   Major Illnesses [2nd year] : ____

4. Describe the **3rd – 5th year** : Easy to care ______ Difficult to care ____

   sleeping pattern: ___________________________ Eating pattern: ________________________________

Major Illnesses [3-5 years] : ____

Form to be used till age 21. **Name:** ________________________________

Describe **the 5th – 10th year :** Easy to care ______ Difficult to care ________________ _________________

sleeping pattern: ___________________________ Eating pattern :____

Major Illnesses [5th – 10th year] : ____

Describe the**10th – year onwards :** Describe your child : ____

Good sleeping pattern: ___________________________ Eating pattern: _______________________________

Major Illnesses [10th year onwards] : ____

SURGERIES: _____No _____Yes

Date	Name and location of hospital	Reason

ACCIDENTS OR HEAD INJURIES: ____ No ____Yes

Date	Name and location of hospital	Reason

ACADEMIC HISTORY

During the child's first five years did he/she attend preschool or day care ? Specify and list the various center:

____ Age: ______________________________

____ Age: ______________________________

School your child attended: incl State. **How does yr child perform in school**

Name of School & City **A's – F's**

Kindergarten : ____ **Grades:** ___________________

1st grade: ____ **Grades:** _____________________

2nd grade: ____ **Grades:** _____________________

3rd & 4th grade: ____ **Grades:** ______________________

5th & 6th grade: ____ **Grades:** ______________________

7th & 8th grade: ____ **Grades:** ______________________

9th & 10th grade____ **Grades:** _______________________

11th & 12th grade ____ **Grades:** ________________________

FAMILY MEDICAL HISTORY

Is there a history on either side of the child's family of any of the following conditions ?

Please Specify:

	MATERNAL	**PATERNAL**
Hyperactivity	____________________	________________________
Learning Problems	____________________	________________________
Mental Retardation	____________________	________________________
Autism:	____________________	________________________
Severe emotional Problems		
. Depression	____________________	________________________
. Anxiety	____________________	________________________
. Obsessive Compulsive Disorder	___________________	________________________
. Bipolar Disorder	_____________________	_________________________
. Schizophrenia	_____________________	_________________________
Seizures	_____________________	_________________________
Alcohol / Drug problems	_____________________	_________________________
Nervous Tics	______________________	_________________________

Other neurological problems (specify) _________________ _____________________

Does your child manifest symptoms of

Condition:	Yes	No	Year observed / diagnosed
Hyperactivity			
Learning problem(s)			
Inattention			
Speech or language problem(s)			
Severe emotional problem(s)			
Requiring hospitalization			
Epilepsy (seizures)			
Congenital (birth) defect(s)			
Mental Retardation			
Alcohol/drug problem(s)			
Nervous tics			
Diabetes			
Thyroid problem(s)			
Eating disorder – Anorexia/Bulima			

Date of Last Physical : ______________________________________

If yes, please describe: ____

____

Are **immunizations up to date? ___ Yes ___ No**

Child is missing which shot(s): ____

Fever or other reactions to vaccines: ____ No ____ Yes If yes, please explain. _______

____

. Child's current weight: ______ Height ______

Appetite is: ____

Growth has been: [ ] On target [ ] Slow. If slow, please explain. ______________

____

DEVELOPMENTAL HISTORY

. Please indicate at what age your child learned to do the following.
[If age is not known indicate: e = early, o=on-time, l=late]

___ Smiled ____ Used single words meaningfully ____ Toilet trained
___ Rolled Over ____ Used short sentences ___ bladder
___ Sat alone ____ Started to feed self ___ bowel
___ Crawled ____ Started to dress self
___ Stood alone ____ Walked alone

. **How does your child communicate ?**
______Crying _______ Words _____ Sign language
______ Playful sounds _______ Phrases _____ Eye pointing
______ Gestures _______ Sentences _____ Electronic talking devices
______ Picture communication board _____ Other [ ]

How much of your child's speech is understandable to you? [ ] some [ ] Most [ ] All

How much of your child's speech is understanding to others? [ ] some [ ] Most [ ] All

. Does your child have any problems in:
____ Following directions ____ Understanding spoken language
_____ Interested in books _____ Understanding TV shows and/or movies

. When compared to other children his/her own age, did your child appear the
a=same, b=slower, c=faster in the following areas of development

_____ coloring _____ cutting ______ running _____ climbing
_____ shoe laces _____ buttoning ______ zippering _____ handwriting

Does your child prefer to play
[ ] alone [ ] with younger children [ ] with same age children [ ] all ages

. What does your child enjoy doing in his/her spare time?___________________________________
____
____

Sports and other activities your child is involved in:
____
____

EDUCATIONAL AND OTHER SERVICES:

What school district do you live in? ____

At what age did your child receive special services :______________ ___________

Is your child in: [ ] self contained class
[ ] regular class
[ ] combination class (describe) ______________________________
[ ] Special education class

[ ] EMR (Educable Mentally Retarded)
[ ] TMR (Trainable Mentally Retarded)
[ ] LD (Learning Disabled)
[ ] OI (Orthopedically impaired)
[ ] MD/MH (Multiple Disabilities)
[ ] EC (Emotionally conflict)

IT IS IMPORTANT THAT WE HAVE A LIST OF PHYSICIANS CURRENTLY TREATING YOUR CHILD/ADOLESCENT

NAME OF THE PHYSICIAN [Purpose]	PHONE & FAX #	ADDRESS
__________________________	__________________	______________________________________
__________________________	__________________	______________________________________
__________________________	__________________	______________________________________

Do we have your permission to contact these doctors for medical records or to discuss treatment if it so requires YES / NO ___________________________

Signature: _______________________________________