The Memory Doctor, LLC
Douglas J. Mason, Psy.D., Licensed Clinical Psychologist
Neuropsychology, Forensics, & Clinical Psychology

Patient's Full Name ____

Parent/Legal Guardian (if patient's POA, please provide a copy)______________________________

Street Address ____

City, State, Zip Code ____

Social Security #____ DOB _____________________

Home Phone #_______________________________________ Work #________________________

Cell #_______________________________________ Email _________________________________

Emergency Contact __________________Relationship _________________ Phone #_____________

May we call your home and leave a message?	□ Yes	□ No
May we call your cell and leave a message?	□ Yes	□ No
For emergencies, may we call you at work?	□ Yes	□ No
May we contact you by email?	□ Yes	□ No
Are you covered by workers compensation?	□ Yes	□ No
Are you involved in a law suit?	□ Yes	□ No
Are you covered by an insurance plan?	□ Yes	□ No

If yes, we require copies of your insurance card(s).

To be filled out by the **Responsible Party**, if other than the patient: (the person responsible for payment of all cost incurred or the Policy Holder of the insurance)

Full Name ____

Social Security # ______________________________ DOB___________________________________

Address ____

Home Phone # ________________________________ Cell # _________________________________

Responsible party's relationship to patient: ( ) Self, ( ) Spouse, ( ) Child, ( ) Parent

Privacy Notice: I acknowledge that I have read and understand the HIPAA Privacy Notice that is posted/provided in this office. A copy will be provided to me upon my request.

____ ____________________________

Patient or Responsible Party Signature **Date**

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Patient Registration

Name____ DOB_____________________

Cancellation Policy: Please be advised that we require a 24-hour advance notice for all cancellations. Missed appointments and delinquent cancellations will be billed to you at your insurance rate. If I miss my appointment or if I cancel or miss 2 consecutive appointments all future appointments will be cancelled. I understand that I am responsible for paying the missed appointment fee prior to any future appointments.

Legal Issues: I understand that Dr. Mason does NOT participate in any legal issues (child custody, workers' comp, auto accidents, etc) unless an attorney or appropriate party has referred me **and** an evaluation and/or treatment is done for that purpose. All legal issues must be discussed and approved by our office prior to any type of medical/mental health services being rendered. I agree to pay for any fees associated with the legal aspects of my care.

Paperwork policy: Please note that most insurance companies will not reimburse us for completing paperwork. We reserve the right to charge for the completion of disability forms and other paperwork not relating to billing. This fee will cover the copying of records and faxing or mailing of original form. This processing fee will start at $25 and will not exceed $200 per incident and will depend on the paperwork required.

Returned Check Policy: There is a fee of $25 payable in cash. All subsequent co-pays must be paid in cash.

Collection Policy: If my account is not paid according to terms, I understand that Dr. Mason's office reports to an outside collections agency. If my account is turned over to collections I agree to pay all additional fees assessed in the collection of the debt.

Insurance: This office will submit claims for insurance companies that we are contracted with. If we are not contracted with your insurance company we will provide you with a receipt that you may submit to your insurance company; however our fees are payable on the date the service is rendered. Please check your insurance carrier to determine if we are in network. It is the responsibility of the patient to know the terms of his/her insurance policies, including deductibles, covered and non-covered benefits, co-payments, etc. If any problems regarding insurance coverage should arise, it is your responsibility to rectify the problem. It is the patient's responsibility to inform the office of any changes in coverage at the time of service. This office will not file any insurance that becomes retroactively effective to services that have already been provided.

Assignment of Benefits/Release of Information: We cannot be responsible for any misinformation you provide us. Actual coverage information and any balances due cannot be accurately determined until an explanation of benefits is received from your insurance carrier. It is your responsibility to ensure all pre-authorizations or certifications are obtained prior to services being rendered. Co-pay, deductibles, and out of pocket expenses are due when services are rendered.

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned health professional. This assignment will remain in effect until revoked by me in writing. Sometimes an insurance company reimburses their insured a portion of the fee that is due to Dr. Mason. In the event that this occurs, I agree that within 5 days, I will remit payment to Dr. Mason. I understand that I am financially responsible for all charges whether or not paid by said insurance. If the time necessary for an evaluation or assessment exceeds that allotted by your insurance, I agree to assume financial responsibility for the difference. If my insurance company does not respond within 60 days from billed date, I will be responsible for contacting my insurance company to ensure payment. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

____ ____________________________

Patient or Responsible Party Signature **Date**

The Memory Doctor, LLC
Douglas J. Mason, Psy.D., Licensed Clinical Psychologist
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Consent for Evaluation & Treatment

I do hereby express my understanding that ____ is to receive psychological /neuropsychological services provided by Dr. Douglas J. Mason.

I understand that I have the option to decline the evaluation/treatment and to request a referral to a different service provider. I was referred by: ____

Limits of Evaluation/Therapy

I understand that psychology is an inexact science and that no guarantees are being made as to outcome or results. I further understand that psychological evaluation/therapy results may not be what I hoped they may be and that Dr. Mason will evaluate the data at hand as objectively as possible to formulate an accurate assessment and implement appropriate treatment. I will not hold Dr. Douglas J. Mason liable for any injury or harm, whether mental, physical, financial, legal, or medical as a direct or indirect result of assessment, evaluation, or treatment.

Limits of Confidentiality

I further understand that my privilege of confidential communication will be maintained by Dr. Mason with the following exceptions:

*Should there be an allegation of abuse or neglect (e.g. child, spousal or elder), Dr. Mason has an obligation to report any pertinent information to the proper authorities and may be asked to testify in court regarding that information and will be subpoenaed to do so.

*Should there be any expressed intention to harm another or oneself, Dr. Mason has an obligation to report this information to the appropriate authorities and to make a reasonable effort to prevent such an action and will do so.

*Should written request for **or** permission for the release of treatment information by provided by me; such information (mental health, alcohol/drugs, HIV/Aids) will be released to the professional individual, agency, or corporation as requested.

*Should there be a court order/subpoena to appear in front of a judge or if your records are requested by a subpoena or court order we must provide the requested records.

I authorize Dr. Mason to discuss my treatment with the following individuals:

____ ____

____ ____

I have read this Consent for Evaluation and I understand it fully and voluntarily sign:

____ ____________________________________

Patient or Responsible Party Signature Date

The Memory Doctor, LLC
Douglas J. Mason, Psy.D., Licensed Clinical Psychologist
Neuropsychology, Forensics, & Clinical Psychology
26540 Ace Avenue, Ste E-106
Leesburg, FL 34748
Phone 352-530-2170 Fax 352-530-2180

Authorization to Release or Use of Information for Treatment, Payment, or Health Care Operations

Patient Name: ____ DOB:___________________

I hereby authorize **The Memory Doctor LLC/Douglas J. Mason, Psy.D.,** to release and/or obtain any and all of the information it possesses relating to my evaluation(s), treatment, and illness(es) including the psychiatric and psychological information which may be part of the medical records to the following individuals on my behalf:

Purpose: ____

Name: ______________________________________ Phone: _________________________________

Name: ______________________________________ Phone: _________________________________

Name: ______________________________________ Phone: _________________________________

Name: ______________________________________ Phone: _________________________________

I give my permission for the information listed above to be shared between the above individuals. I understand that as per HIPAA my protected health information and medical information including the results of my Neuropsychological evaluation may be shared for continuity of care. Should there be a court order/subpoena to appear in front of a judge or if your records are requested by a judge or court order, we must provide the requested records. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization is valid until revoked in writing. The requestor should not **re-disclose** my medical records to another party without further written consent (FS 456.057(12)).

I will not hold Dr. Douglas J. Mason liable for any injury or harm, whether mental, physical, financial, legal, or medical as a direct or indirect result of assessment, evaluation, or treatment.

Place your initials by each specific item to be disclosed.

____ **Neuropsychological Evaluation Report** (may include mental health, substance abuse, (e.g. drugs/alcohol) and or HIV/AIDS status information, diagnostic and treatment records)

____**Mental Health** _____ **Drug and/or Alcohol** ____ Psychotherapy Notes

____Treatment Summary _____ HIV Testing/AIDS Information ____ Medical Psychological Clearance

____ Other_____________________________

____ ________________________________

Patient or Responsible Party Signature **Date**

History Form

Patient Name: ____ **DOB:** __________________ **Salutation:** Dr/Fr/Mr./Mrs./Ms/Miss

SEX: Male/Female **Handedness:** Right/Left **Highest Level of Education:** ______________________ **Race:** ____________________

Current/Past Occupation (s):____

Social History:___ Married ___Single ___Divorced ___Widowed ___Living w/Significant Other Name _________________________

Do you have a Power of Attorney __Yes __No (Must Provide) **Children**: ___Yes ___No **Names**_____________________________

Sexual History: Are you sexually active: __Yes __No Sexual Partners past year:____ # men___ # women___ Any STD's ___________

How Much Alcohol do you Consume Daily/Type_________________________ **Is there a History of Substance Abuse** ____________

Tobacco Use: __Yes __No Type: _________Quit ____________(year) Interested in Quitting __Yes __No

Presenting Problem(s) ____

Medications: Please list all medications or herbal supplements you take and their dosage:

Drug:	Dosage:	Drug:	Dosage:

Allergies / Reactions: _____________________________________

Names of current doctors:

Doctor	Phone Number:	Doctor:	Phone Number:

Past Psychiatric / Psychological Diagnoses and Year:____

Have you ever Attempted Suicide, if yes explain: ____

List any Current/Past Medical Conditions and Year: ____

List any Neurological/History and Year: ____

Operations: List names and dates of all operations:

Year	Name of Operation	Type of Anesthesia	Complications

Have you or any blood relative had:	Yes	No	Who	Year
Substance use/abuse	____	____		
Alzheimer's/Dementia	____	____		
Depression/Anxiety	____	____		
Epilepsy or seizures	____	____		
Parkinson's	____	____		
Stroke	____	____		
Head Injury (Self)	____	____		
Toxic Exposure (Self)	____	____		
Other Conditions	____	____		

List Test Done in the Past Year and Place Done Imaging (MRI, CT, PET), EEG, Neuropsychological Testing.

The above information may be disclosed in accordance with the HIPAA Privacy Act.

Signature ____ Date: _______________________