Dr. Ilyse O'Desky
26 Linden Avenue, Springfield, NJ 07081
(973) 376-5511

NEW PATIENT INFORMATION FORM (CHILD)

DATE: _____

PATIENT'S NAME: _____

ADDRESS: _____

_____

_____

HOME TELEPHONE #: _____

WORK TELEPHONE #: _____

PATIENT'S DATE OF BIRTH: _____

IF A CHILD: GRADE: _____

SCHOOL: _____

REFERRING PHYSICIAN OR PERSON: _____

****

Reason for Referral: _____

_____

_____

Previous Testing (when and by whom): _____

_____

_____

_____

Date of Last Physical Exam: _____

Problems? _____

_____

_____

Current Medications: _____

_____

_____

Developmental History: Please check if there were any problem areas:

___ Prenatal History ___ Language skills ___ Gross motor skills

___ Fine motor skills ___ Social skills

Dr. Ilyse O'Desky
26 Linden Avenue, Springfield, NJ 07081
(973) 376-5511

List Serious Illnesses/Injuries/Hospitalizations/Surgeries/Chronic Conditions:

Age of Occurrence Incident

_____

_____

_____

_____

Please check if patient has had any of the following:

_____ Febrile Seizures
_____ Lead Poisoning/Toxic Ingestion
_____ Headaches
_____ Sleep Difficulties
_____ Tics/Twitching
_____ Impulsivity
_____ Nail Biting
_____ Self-Injurious Behavior
_____ Repetitive/Stereotyped Movements (hand-flapping, spinning in circles, or rocking)
_____ Loss of Consciousness
_____ Asthma or Allergies
_____ Frequent Ear Infections
_____ Eating Difficulties
_____ Clumsiness
_____ Temper Tantrums
_____ Head Banging
_____ Fights with Others
_____ Difficulty caring for basic needs (feeding or hygiene)

Please check if there is a family history of any of the following:

_____ Epilepsy or other seizure disorder
_____ Psychiatric Disorder
_____ Attention or Memory Problem
_____ Learning Disorder
_____ Mental Retardation
_____ Autistic Spectrum Disorder

Notice of Patient Privacy Practices

I acknowledge that I have received a copy of the practice's notice of patient privacy practices.

Signature:_____ Date:_____

Dr. Ilyse O'Desky
26 Linden Avenue, Springfield, NJ 07081
(973) 376-5511

Permission of Patient Contact
(Effective April 14, 2003 under Federal Law)

Contact Information: This information will allow this office to contact you with appointment reminders or other information relevant to billing or treatment.
Please fill out the bottom portion in its entirety.

Please list two phone numbers that we may use to contact you:

1. Phone #: _____ 2. Phone #: _____

In the event that Dr. O'Desky or her associate is unable to reach you concerning your status with this office (i.e. appointment, test results, billing statements, etc.) may we leave a message on your:

Home answering machine Yes _____ No _____
Cellular voice mail Yes _____ No_____
Work voice mail Yes _____ No_____

If I need to contact you at work and you are unavailable, may I leave a message with the receptionist for a call back to my office? Yes No

Please list the names of any person or persons that may be involved in your treatment that I may be permitted to discuss anything concerning your medical status (i.e. practitioner or, parent, etc). Please note, if a name is not listed, I am required by law to protect your information and I will not discuss anything pertaining to your healthcare with that unlisted person.

Name: _____ Name _____
Address: _____ Address _____
_____ _____
Phone number _____ Phone number _____

Patient Name: _____ Date: _____/__ /_____

Signature: _____ Relationship: _____
(Parent or Guardian if patient is under 18 yrs old)

* Please keep this report in a secure place. As a courtesy, upon signing this release form one copy of this report will be forwarded to a source you designate on this form. You are free to make additional copies to send to other professionals. If any additional copies are required from us, a $50 fee will be required for each copy.

**Please note that effective April 14, 2003, the law requires a written notice for any changes or additions to the information that you have listed above. Any verbal communication of changes or additions will not be honored by our office.

Dr. Ilyse O'Desky
26 Linden Avenue, Springfield, NJ 07081
(973) 376-5511

Neuropsychological Testing Service

GUARANTEE OF PAYMENT: For value received, the undersigned guarantor and/or patient (hereinafter the "Responsible Party") promises to pay to Dr. Ilyse O'Desky all charges incurred for services rendered to the Responsible Party.

Dr. O'Desky will provide the Responsible Party with a form to submit to the insurance company for reimbursement. Dr. O'Desky cannot guarantee that each service will be covered or what percentage will be covered. However, it is understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by Dr. O'Desky and it is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Responsible Party.

A minimum of 24 hours notice is required for cancellation of appointments. If this notice is not received, the Responsible Party may be charged for the full amount of time which was reserved for the appointment at the agreed upon rates. Insurance may not be billed for missed/canceled appointments.

In the event this account is turned over to a collection agency, the Responsible Party hereby agrees to pay all costs of collection including, but not limited to, 35% of the fee to be collected and court costs. The Responsible Party agrees to be bound by the terms and conditions of this account with Neuropsychological Testing Center.

In the event that the bank returns the check to Dr. O'Desky, the Responsible Party will be billed for the initial amount of the check as well as a $25.00 fee for processing the returned check.

Dr. O'Desky will work with the Responsible Party regarding payment (e.g., setting up a payment plan). Dr. O'Desky expects full payment within ninety (90) days of the date of service unless prior arrangements have been made. The Responsible Party hereby agrees that accounts not paid within thirty (30) days will be charged a late fee of $15.00 and will accrue interest at the rate of 1.5% per month (18% A.P.R. - a minimum of $1.00 will apply). The Responsible Party bears ultimate financial responsibility for all services rendered to the Patient/Responsible Party.

NOTE: Testing includes time for (1) administering and (2) scoring the tests, (3) reviewing records, (4) preparing the report, and (5) discussion of the results (feedback). In nonforensic/nonmedical cases, this will typically add 3-4 hours to the actual testing time. Forensic/medical-legal cases typically require even more time and generally include a more extensive record review and consultation(s) with attorney(s), etc.

If you have any questions, please speak with Dr. O'Desky. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

_____ Date: _____
Patient Signature:

_____ Date: _____
Parent/Guardian Signature
(if patient is a minor or unable to sign**):

****If patient is a minor, are you his/her legal guardian?** [ ] YES [ ] NO
If **NO**, please see Dr. O'Desky regarding this matter.