INNOVATIVE
HEALTH CARE CONCEPTS
The Testing Center

PRINT FORM

RESET FORM

111 E. 16th Street | Idaho Falls, ID 83404 | t. 208.523.1130 | f. 208.529.6501

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TESTING CENTER INTAKE PACKET

Thank you for choosing Innovative Health Care Concepts for your psychological evaluation needs. Please read the instructions below carefully.

Complete the following forms in this packet:

1. Testing Screening Form
2. Testing Center Patient Admission
3. Distribution of Completed Evaluation

Return the completed forms using one of the methods below:

Mail:
Innovative Health Care
111 East 16th Street
Idaho Falls, ID 83404

Fax: 208.529.6501

Email: testing@ihccinc.com Follow the instructions below:

- Each time you electronically sign the document, you will be prompted to save it to your computer. Take note of where the document is saved. Continue to replace the saved document each time you are prompted so that only one document is saved when you have finished.
- Open your email browser and compose an email to testing@ihccinc.com
- Attach the saved document from your file and send.
- NOTE: Complete ALL form pages before digitally signing any of the signature fields. Once any page has been electronically signed, the form you are filling in can no longer be changed.

GUARDIANSHIP

Be sure the parent/guardian has signed all paperwork and completed all initial sections. Keep in mind, there are three sections that will require your initials on the Patient Admission Form, as well as your signature at the end of the Patient Admission form and at the end of the Distribution form. We will only accept signatures from the following:

- If you are 18 or older and you are your own guardian, you may sign the paperwork
- If the patient is a minor child and you are their parent and legal guardian, you may sign the paperwork
- For all other signatures, we will require a copy of any guardianship papers indicating who the legal guardian is
    - We are not able to accept signatures of Step-parents or Grandparents as the legal guardian without court documentation indicating legal guardianship. The legal guardian will have a chance to sign a release of information to allow communication with step parents and /or grandparents at your initial appointment, or you may access the Release of Information form under the FORMS tab on our website and include it with your intake packet.

CHILD CUSTODY

Our policy regarding child custody issues are as follows:

- Our psychologists will not testify in court as to the appropriateness of one parent over another.
- If testimony is required, our psychologists will only testify as to the patient's diagnosis and recommendations for treatment. This may be done only under subpoena and by recorded deposition. There is a charge for this service.
- Biological parents have the right to access information about their child, including appointment times, the testing process, and the final evaluation. Biological parents may complete parent testing booklets and give input regarding the initial intake appointment. The only time we refuse communication with a biological parent is if we have court documentation indicating guardianship and custody that negates us from speaking to an identified biological parent.

Are there any custody issues we should be aware of? ❒ YES ❒ NO
If you answered yes, please call our office to discuss at (208) 523-1130

Once we have received all completed documentation, we will call you to schedule your initial appointment. You will receive detailed information at your first appointment regarding our process for testing and what to expect. Please read this information carefully.
All forms must be completed in order to schedule an appointment. If you have any questions, please contact us at (208) 523-1130.

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PSYCHOLOGICAL TESTING SCREENING FORM

The purpose of this screening form is to determine the best placement for you or your child with the most appropriate psychologist / neuropsychologist to meet your needs, and to determine medical necessity requirements for the purpose of insurance coverage.

Today's Date: _____ Patient Name: _____ DOB: _____

Who do we contact regarding scheduling appointments? _____

Relationship: _____ Daytime Phone: _____

How did you hear about our services? ❒ Doctor referral. Name of Doctor: _____

❒ Other: _____

Have you ever had a psychological evaluation in the past? ❒ Yes ❒ No

If yes: Date:_____ Doctor:_____

Since your last evaluation, are there any changes? ❒ No changes ❒ Worsening Symptoms ❒ Improved Symptoms ❒ N/A

Reason for Testing: (check all that apply) ❒ Need eligibility for DD services ❒ Enrolled in DD services and need update only
❒ Mental Health Issues ❒ Behavioral issues ❒ Court Ordered (include copy)
❒ Need recommendation for the following service: _____
❒ Neurocognitive Problems, please specify: ❒ Development is Delayed ❒ Language / Communication Problems ❒ Memory / Learning problems ❒ Struggling in school ❒ Poor Motor Skills ❒ Poor Executive Skills (e.g., attention, organization, impulsivity)
❒ Other: _____

Answer the following questions in regard to the patient who is going to receive the evaluation.

Are there any past or present medical disorders? (i.e. seizures, head injury, serious illness, significant fever, heart problems, etc.)

Are there any past or present mental health disorders? (i.e. behavioral disorders, ADHD, anxiety, depression, etc.)

Were there any complications before, during, or after pregnancy? If so, please briefly explain.

Please list any Mental Health Disorders that you would like evaluated. (ADHD, depression, anxiety, bi-polar, schizophrenia, PTSD, OCD, etc.)

Please list any Developmental Disorders that you would like evaluated. (Autism, intellectual disability, executive processing, delays)

PLEASE NOTE: Dr. Faraday, our Pediatric Neuropsychologist, does NOT evaluate mental health disorders. She evaluates neurocognitive disorders and the way your brain processes information. If you specifically want a mental health disorder evaluated (such as bi-polar, anxiety, depression, etc.) and that is the purpose of seeking a psychological evaluation, you will be placed with a psychologist who specializes in standardized mental health evaluations. Please indicate by completing the section above.

Are you wanting an evaluation to determine the presence of a Learning Disability? ❒ Yes ❒ No If Yes, see below:

CLEAR THIS PAGE

PLEASE NOTE: In order to assess a Learning Disability, the patient must be evaluated for academic performance. Many insurance companies to NOT cover the cost of academic evaluations. If you checked **Yes** to the above question, please ask our office for additional information regarding out of pocket cost for academic testing.

Any issues with hearing? ❒ Yes ❒ No ❒ I don't know – never been tested
Any issues with vision? ❒ Yes ❒ No ❒ I don't know – never been tested

Please list any other comments you feel we need to know in order to schedule your evaluation:

Please list ALL service providers and service types you or your child receive services from. This will allow us to collaborate and coordinate services with your written permission. Please fill in all applicable sections below.

Service Type	Name and Agency/School	Contact Number
Primary Care Physician		
My child is on an IEP – list school:		
Case Manager/Service Coordinator		
Counselor		
Psychiatrist (Medication Management)		
CBRS Worker		
Developmental Disability Agency		
Occupational Therapy		
Speech Therapy		
Physical Therapy		
Pain Management Doctor		
Neurologist		
Genetic Testing done by:		
Probation Officer/Jump Court		

Please list all medications patient is prescribed, the dosage, and reason for taking the medication. Attach additional sheets if necessary. It is very important to provide this information accurately. If left blank, your appointment will not be scheduled.

Name of Medication	Dosage	Reason for taking

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IHCC TESTING CENTER PATIENT ADMISSION

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Patient Information

Name: _____ DOB: _____ Age: _____

Gender: ❑ Male ❑ Female

Primary Language: _____ Do you require interpretive services? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip Code: _____

How would you like to receive reminders for your appointments? ❑ Phone Call ❑ Text ❑ Email ❐ All are fine

Phone: 1st contact #: _____ 2nd contact #: _____ Email: _____

Responsible Party/Guardian Information

Name: _____ DOB: _____

❑ *Check if address and contact numbers are the same as above*

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: 1st contact #: _____ 2nd contact #: _____ Email: _____

Relationship to the patient: ❑ Self ❑ Parent ❑ Spouse ❑ Child ❑ Other: _____

Insurance Information:

Primary Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ DOB: _____

Relationship to the patient: ❑ Self ❑ Parent ❑ Spouse ❑ Child ❑ Other: _____

Secondary Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ DOB: _____

Relationship to the patient: ❑ Self ❑ Parent ❑ Spouse ❑ Child ❑ Other: _____

Physician Notice and Release:

Most insurance plans request that your primary care physician be notified if their patient is being seen for testing or counseling. By checking "Yes" below, you are also authorizing us to send your completed evaluation to your Primary Care Physician.

Primary Care Physician: _____ Phone: _____

❐ Yes, you may give notice to my primary care physician that I am receiving testing or counseling services and send a copy of my finished report to them.

❐ No, you may NOT give notice to my primary care physician that I am receiving testing or counseling services

Please complete the attached Distribution List for sending your completed evaluation out. If you do not complete the distribution list, your completed evaluation will only be sent to the responsible party listed above and the Primary Care Physician if indicated "Yes" above. We will distribute your evaluation via fax to anyone indicated free of charge. We will provide via pick up or mail an original evaluation to the responsible party free of charge. We will provide a copy to your Primary Care Physician free of charge. Any additional copies requested will be charged at a fee of $2.00 per evaluation and available for you to pick up. If you would like additional copies mailed, a charge of $3.00 per evaluation will be charged and mailed upon payment. **Initial** _____

Please ensure you have initialed the above paragraph, as well as the two sections requiring initials on the following page.

Authorizations, Disclosures, Terms, and Conditions for Services

CLEAR THIS PAGE

Insurance/Payment Policy:
Insurance, including Medicaid, provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Payment options will be reviewed with you prior to testing. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. All accounts with an outstanding balance over 120 days or more will be subject to collections. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorney's fee.
I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. **Initial** _____

Cancellations:
If you are unable to attend your scheduled appointment, please contact us 24 hours prior to your appointment. Without a 24-Hour notification, you will be assessed **a $35.00 cancellation fee.**

Medical Consent:
I consent to the services which may be performed as a patient, on an outpatient basis, within the scope of practice authorized under the licenses of the respective licensed providers. For purposes of this agreement, the term, "Medical" shall refer also to psychological, neuropsychological, mental health, or behavioral services. In agreeing to participate in testing, I understand the patient will be tested using standardized testing tools to assess cognitive, adaptive, and behavioral functioning. A list of possible testing procedures will be provided upon request. I understand that if the patient has a history of Autism Spectrum Disorder (PDD-NOS, Asperger's Disorder, Autistic Disorder), testing for Autism Spectrum may be recommended. This may include the ADOS-2 and/or GARS as part of the battery of tests that will be performed. I understand and agree that a professional serving as a service extender under a neuropsychologist or psychologist licensed in the State of Idaho may be involved in my care, including, but not limited to initial diagnostic examinations and neuropsychological or psychological assessment and testing. **Initial** _____

Association:
I understand that some clinicians provide services under contract with Innovative Health Care Concepts, Inc. (IHCC), and IHCC is responsible for support services and the collection of fees for rendered services. IHCC will be seeking reimbursement for services from Medicaid, Insurance benefits for which psychologists and clinicians may be eligible, and responsible parties.

Release of Information:
I acknowledge that IHCC will use my information for the purpose of diagnostics, assessment, payment, and health care operations. I authorize IHCC, and any staff member involved in my care, to release medical information and supporting documentation of the same as compiled in my medical records during the time of services or reasonable follow-up period to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. I acknowledge that data from my patient records will be accessible to all health care, social service providers, and educational institutions participating in my care and treatment, including but not limited to physicians, psychiatrists, therapists, diagnosticians, nurses, technicians, and such other health care or mental health care agencies involved in my care with a valid of release. This information may also be provided to educational institutions in which the patient is enrolled upon request. I further acknowledge that my medical records may be utilized in IHCC's utilization review. I also acknowledge that information contained in my medical records may be extracted and compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public. I acknowledge that my medical records may also be made available to governmental agencies as required by law. I acknowledge that patient medical records may be stored electronically and made available through secure computer networks to IHCC staff personnel.

Final Report:
I acknowledge that final diagnosis, test results, impressions, and formal report will be provided to consented parties only after the consultation and examination by the neuropsychologist or psychologist. Should I cancel or decline to complete the evaluation and/or appointment with the neuropsychologist or psychologist, test data, results, and report will not be released.

Certification of true, correct, and complete information:
I certify that the information given or will be given by me or upon my behalf is true, correct, and complete. I certify that I have not nor will not withhold any information that is reasonably requested. I understand that withholding information can have a serious negative impact on the quality of services provided, including resulting in an inaccurate diagnosis. This includes but is not limited to prior medical, mental health, or behavioral history; family history of potentially related medical, mental health, or behavioral symptoms; use of pre-natal use of alcohol, drugs, or tobacco; pre-natal and birth abnormalities or incidents; child abuse or injury; injuries to the head; history of cancer or blood disease, etc.

I hereby certify and state that I have read, and that I fully and completely understand the conditions for services, and that I sign knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained based upon the diagnoses or results from assessment or testing completed. I further certify that the information I provide is true, correct, and complete, and certify the foregoing acknowledgements, understandings, and certifications.

Client or Responsible Party Printed Name	Relationship to Client
Patient or Responsible Party Signature *(check to be sure you initialed at top twice)*	Date

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DISTRIBUTION OF COMPLETED EVALUATION

CLEAR THIS PAGE

PATIENT NAME: _____ **DOB:** _____

Please complete the Distribution List below so we can efficiently distribute your completed evaluation. If you do not complete the distribution list, your completed evaluation will only be sent to the responsible party and the Primary Care Physician if indicated "Yes" on your Admission Form. List their contact information including phone, fax, and address if possible. Without current contact information, we may be unable to distribute the completed evaluation.

Statement of Charges:

We will distribute your evaluation via fax to anyone indicated below free of charge. We will provide, via pick up or mail, an original evaluation to the responsible party free of charge. We will provide a copy to your Primary Care Physician free of charge. Any additional hard copies requested will be charged a fee of $2.00 per evaluation and available for you to pick up. If you would like additional hard copies mailed, a charge of $3.00 per evaluation will be charged and mailed upon payment. For mailed evaluations, we must have a signed Release of Information for the receiving party or they must be listed on the Distribution List below. Credit and Debit card payments may be made over the phone.

Distribution of Completed Evaluation:

You evaluation will be automatically distributed to the patient's Responsible Party and you do not need to indicate that information below.

❒ Check this box if you checked "Yes" on the Patient Admission form to allow distribution to your Primary Care Physician. If so, you do not need to indicate your Primary Care Physician below as long as you have provided that information on the Patient Admission Form.

Please indicate any additional locations for distribution of your completed evaluation. When a fax number is available, we will fax your evaluation free of charge. Please see statement of charges above.

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

My signature below consents to the release of this patient's completed psychological evaluation to those individuals listed above. I have read the Authorizations, Disclosures, Terms, and Conditions for Services on the Patient Admission Form and consent to all terms and conditions.

_____
Printed Name of Patient or Guardian

_____ _____
Signature of Patient or Guardian Date

CLEAR THIS PAGE

FOR CHILDREN ONLY

Parent Conflict Disclosure

Please read and check the appropriate box below. Please sign at the bottom of the page.

In the event a child is referred for testing and there is conflict present between both biological parents, especially in cases of divorce, pending divorce, marital conflict, or separation, the parent who initiates the request for testing and attends the intake appointment will be responsible to disclose to the other parent or legal guardian about the assessment and the opportunity to complete parent forms and provide feedback regarding the child. Please understand it is not the responsibility of Innovative Health Care and/or it's providers to mediate conflict regarding the child's assessment between conflicting parents.

Innovative Health Care will provide the following if requested:

- If parents wish to complete separate parent forms due to conflicting views, an additional set of parent forms may be provided upon request for the second parent at a cost of $4.00 per booklet.
- If the parent not present at the intake appointment wishes to provide feedback typically obtained at the intake appointment, they may call to schedule a separate appointment with the provider or they may submit a completed "Dr. Faraday Pediatric History Form" found on our website under the Forms tab at ihccinc.com
- If parents would like to meet separately to review results of the assessment and discuss recommendations, we can accommodate this. Each parent may call to schedule their individual appointment.

It is the responsibility of the parent to contact us in order to receive additional booklets and/or schedule additional appointments.

Please initial the appropriate line:

_____ There is no conflict between both biological parents regarding the evaluation.

_____ I feel there is a conflict. I understand it is my responsibility to inform the other parent of these proceedings and it is the responsibility of the other parent to obtain and pay for additional parent booklets, submit additional information, and/or schedule additional appointments.

Printed Name of Parent/Guardian _____ Relationship _____

Signature of Parent/Guardian _____ Date _____