Antonio E. Puente, Ph.D.

Tele: 910.509.9371 **Neuropsychology** Fax: 910.509.9372

1508 Military Cutoff Road, Suite 303
Wilmington, NC 28403
clinicalneuropsychology@gmail.com

Patient/Client Information:

Date: ______________________ Referred by: ______________________

First Name: ______________________ Middle: ______________________ Last: ______________________

Address: ______________________ City/State: ______________________ Zip: __________

Phone: Day: ______________________ Evening: ______________________ Cell: ______________________

Social Security Number: ________ - ________ - ________ Date of Birth: ______________________ Age: ________

Sex: M F Race/Ethnicity: ______________________ Student: Y N Years of Education: ______ Handedness: R L

Marital Status: Single Married Other Name of Spouse/Partner: ______________________

Employed: Y N Employer's Name/Telephone: ______________________

Is condition related to: Employment? Y N Auto Accident? Y N Other Accident? Y N

If you answered *Yes* to any of the above three questions, please briefly describe the accident: ______________________

____

Financial Information of Responsible Party/Legal Guardian (if applicable):

Name: ______________________ Relationship: ______________________

Address: ______________________ City/State: ______________________ Zip: __________

Phone: Day: ______________________ Evening: ______________________ Cell: ______________________

Social Security Number: ________ - ________ - ________ Date of Birth: ______________________ Age: ________

Employer's Name: ______________________ Employer's Phone: ______________________

Employer's Address: ______________________ City/State: ______________________ Zip: __________

Emergency Contact:

Name: ______________________ Relationship: ______________________

Address: ______________________ City/State: ______________________ Zip: __________

Phone: Day: ______________________ Evening: ______________________ Cell: ______________________

Insurance Information: *Please bring insurance card(s) and a photo ID to the check-in desk.*

Insurance Co. #1: ______________________ Insured's Name: ______________________

Relationship to Patient/Client: ______________________ DOB: ______________________

Insurance Co. #2: ______________________ Insured's Name: ______________________

Relationship to Patient/Client: ______________________ DOB: ______________________

Insurance Authorization and Assignment:

I hereby authorize Antonio E. Puente, Ph.D. to furnish information to insurance carriers and in such cases, to my others, as applicable, or to the Center for Medicare and Medicaid services and its agents concerning my illness and treatments. I hereby authorize payments for health services rendered to myself or authorize Medicare benefits, if applicable, to be made either to me or on my behalf to the above named health provider. I understand that I am responsible for any amount not covered or reimbursed by insurance.

______________________ ______________________

Patient/Legal Guardian's Signature Date

______________________ ______________________

Insured's Signature Date

A photocopy of this authorization and assignment shall be considered as valid as the original.

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Payment Policy

Cancellation:

A minimum of 48 hours of notice is required for cancellation of appointments. If this notice is not received, you may be charged for the full amount of time that was reserved for your appointment. This may include legal fees associated with subpoenas, depositions, and other court-related activities. Insurance cannot be billed for missed or cancelled appointments.

Copay:

Your copay is expected at the time of service.

Insurance Filing and Coverage:

We will file our initial insurance claim(s) and provide documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. You may incur extra charges for refilling of insurance claims. If a service is not, or is only partially covered according to our understanding of your insurance policy, the service may be provided to you as long as you understand that there is no or limited coverage, and that you will be responsible for the costs of the service.

Payment:

In the event that your insurance does not cover our services (or any portion thereof) we will work with you regarding payment (e.g., setting up a payment plan). We expect full payment within thirty days of the date of service. The undersigned hereby agrees that interest at 12% per annum may be due, and owing on this account and said interest may begin thirty days after the principal is due. You bear ultimate financial responsibility for all services rendered to you, including workers' compensation claims and personal injury cases, regardless of the outcome of litigation. In the event that coverage is denied under workers' compensation, you will pay the unpaid balance, notwithstanding any appeal of such denial. With respect to personal injury cases, you are responsible for fees incurred, we may not be able to seek payment from third parties, and we cannot wait on the outcome of pending litigation for payments. We do not accept contingency fee arrangements. If there is any remaining balance(s) due at the time of settlement, you hereby authorize your attorney to clear your outstanding accounts. Your signature also constitutes your irrevocable agreement to a waiver permitting payment of health insurance claims directly to Antonio E. Puente, Ph.D. prior to claimant receiving such funds.

Forensic Cases:

Responding to discovery requests, conferences, and phone calls with attorneys involve additional time and recordkeeping. Additionally, the patient or responsible party is responsible for all direct costs and expenses associated with Antonio E. Puente, Ph.D. and the attorney or legal representative responding to discovery requests (including dispositions) and with these conferences including, but not limited to, court appearances, preparation of reports, photocopying, faxes, long distance travel, telephone, overnight delivery, and courier services. These expenses are billed to the patient or responsible party and to the patient's attorney. Patient or responsible party, however, remains primarily responsible for payment of these charges if not paid in full within thirty days.

Note. Testing includes time for (1) selection of tests, (2) administering of tests, (3) scoring of tests, (4) interpretation of tests, and (5) discussion of results (feedback). In certain cases (such as, but not limited to, medical-legal cases), a more comprehensive and time-consuming assessment may be needed than what may be approved under your insurance plan. The responsible party, as noted below, accepts responsibility for these charges.

Guarantee of Payment and Assignment of Insurance Benefits:

For value received, the undersigned guarantor and/or patient (hereinafter referred to as "the Undersigned") promises to pay to Antonio E. Puente, Ph.D. (hereinafter referred to as "Provider") all charges incurred for services rendered to the Undersigned. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) but only as a courtesy to the Undersigned, and the Undersigned authorizes Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by Provider in the event insurance does not pay for these services. It is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Undersigned. It is further agreed upon by the Undersigned that if, in the event that any monies received by Provider from the insurance carrier are at any time after their receipt withdrawn from Provider by the insurance carrier, the Undersigned will be responsible for those monies that due and owing, and waives any defense for payment that Undersigned may have against Provider. In the event that this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs, but including reasonable attorney's fees. The Undersigned authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized.

Liability:

We will do everything possible to safeguard our safety. However, please note that once you are outside the confines of our office suite, we are no longer able to safeguard your safety.

If you have any questions, please speak with our Office Manager, Dawn Benton, or with Dr. Puente directly. Your signature below indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

____ ____________________________

Client's Signature Date

____ ____________________________

Witness' Signature Date

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Notice of Privacy Practices

Uses and Disclosures

Assessment and Treatment:

Your health information may be used by staff members or disclosed to other care professionals for the purpose of evaluation your health, diagnosis of health conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your health record to all health professionals who may provide treatment or who may be consulted by staff members.

Health Care Operations and Research:

Your health information may be used as necessary to support the day-to-day activities and management at the practice of Antonio E. Puente, Ph.D. In addition, information that does not reveal your identity may be used by Dr. Puente for research purposes. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality improvement. Nonetheless, in all cases, your anonymity will be maintained.

Law Enforcement:

Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, for the protection of yourself and others, and to comply with mandated government reporting, as required by law.

Other Uses and Disclosures Requiring your Authorization:

Disclosure of your health information or its use for any purpose other than those listed above requires your specific, written authorization. If you change your mind after authorizing a use of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or reverse any use or disclosure of information that may have occurred before you notified us of your decision.

Additional Uses of Information:

Your health information may be used by our staff to remind you of your appointment.

Information about Treatments:

Your health information may be used in order to send you information concerning the treatment and management of your condition. We may also send you information regarding other treatments, options, or related services.

Duties of Antonio E. Puente, Ph.D.:

We are required by law to protect the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required by law to abide by the privacy policies and practices that are outlined in this notice.

Individual Rights:

You have certain rights under federal privacy standards. These individual rights include the following:

- The right to request restriction on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Right to Revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information:

As permitted by federal regulation, we require that any request to inspect the copy protected health information must be submitted to us in writing. You may obtain a form to request access your records by contacting us directly.

Request for Restrictions on Protected Health Information:

You have the right to request us to restrict how we use and disclose your protected health information. However, we are not required by law to agree with your requested restrictions in certain situations. These situations may include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and/or any uses and disclosures described previously in this notice. However, if we decide to grant your request then we are bound by your agreement.

Complaints:

If you would like to submit a comment, concern, or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Antonio E. Puente, Ph.D.
1508 Military Cutoff Road, Suite 303
Wilmington, NC 28403

If you believe that your privacy rights have been violated and you call the matter to our attention by sending a letter describing the cause of your concerns to the same address, then you will not be penalized for filing the complaint.

By signing below, I am hereby certifying that I have read, agreed to, and received a copy of the Privacy Practices for the office of Antonio E. Puente, Ph.D.

____ ______________________________

Client's Signature Date

Antonio E. Puente, Ph.D.
Neuropsychology
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Authorization for Release of Protected Information Form

HIPAA is a federal regulation that gives patients greater control over their medical information. I understand that Dr. Antonio E. Puente, Ph.D. must release testing data* to anyone that I designate, regardless of the qualifications of the individual who would receive the data. Dr. Puente has informed me that releasing the raw data to myself, or to another individual who may subsequently disclose this information to me, might result in problems if I am in need of any future testing. Dr. Puente has explained the possible consequences and potential harm of disclosing raw data to me when such data is documented on testing materials.

I have been informed that seeing the test questions, my answers to such questions, and/or the scores that I received might affect my performance on any subsequent testing, and I might lost the advantage of an unbiased assessment in the future. I have also been informed that the circulation of such questions and answers can negatively affect the validity of psychological testing for others whom are in need of them. This form, when completed and signed by me, authorizes Dr. Puente to release this protected information from my clinical record to the person/entity that I designate. I have read in entirety, and I understand the possible consequences.

I understand that the fact that it will be documented that I have received my raw testing data, and that this documentation will be attached my evaluation report. This will mean that at anytime in the future, if I, or anyone else, request a copy of my report, that this documentation will be included.

* Testing data refers to the following:

- Raw and Scaled Scores of Tests
- Client/Patient responses to test questions or test stimuli
- Psychologist's notes and/or recordings concerning client/patient responses during the examination and/or interview, as well as of client/patient behavior during the examination and/or interview.

Testing data do not include *test materials*. The term *test materials* refers to the following:

- Testing Manuals
- Instruments/Testing Apparatus
- Protocols for test administration and/or scoring
- Test questions

Regarding HIPAA, the new American Psychological Association (201) Ethical Principles of Psychologists and Code of Conduct states in Section 9.04 that testing data can be released to myself or to a person of my choosing if I sign a release of my information. In the absence of my release, my testing data can, and will, only be disclosed as required by law or court order.

I authorize Dr. Antonio E. Puente and the administrative and clinical staff to release the following item(s) that I have checked as YES. I do *not* authorize the release of the items that I have checked as NO.

A. Neuropsychological Evaluation Raw Testing Data: _____ YES _____ NO

B. Psychological Evaluation Raw Testing Data: _____ YES _____ NO

C. Educational Evaluation Raw Testing Data: _____ YES _____ NO

D. Other (Please provide a description of the information that you *want* to be disclosed. Your description should be as specific and detailed as possible.):

____
____
____

This information should only be released to the following person(s)/agencies:

____
____
____

I am requesting for Dr. Antonio E. Puente to release this information for the following reason(s) (If you are a registered patient and do not desire to state a specific purpose, please write "at the request of the individual".):

____
____
____

This authorization shall remain in effect until (date) ______________ or until the following event that relates to the patient/client or the purpose of the disclosure occurs: ____________________________________.

As a patient, I have the right to revoke this authorization, in writing, at any time by sending such written notification the office address below. However, I cannot revoke any copies of my report that have already been sent out based on my earlier permission to do so. In addition, I cannot revoke my permission to send a copy of the report to my insurance company, if that was a condition of obtaining insurance coverage, and thus the insurer has the legal right to contest the claim.

Send written notification of revocation of authorization for release of protected information to:

Antonio E. Puente, Ph.D.
1508 Military Cutoff Road, Suite 303
Wilmington, NC 28403

I understand that once I authorize the release of my records to another person and/or agency, that there is no guarantee that my records will remain in confidence, and that it is possible that my records maybe sent to other individuals. In theory, that individual may disclose protected health information for the proper management and administration of that individual, provided that the disclosures are required by law. That information is no longer protected under HIPAA, and the individual who received my records can disclose of the information to someone else without my authorization.

I understand that my decision to sign or not to sign this authorization will not affect the provision of psychological services by University Neuropsychology and or Dr. Antonio E. Puente unless the psychological services are provided to me for the purpose of creating health information for third-party.

For patients/clients who are legally incapable of giving informed consent, Dr. Antonio E. Puente will do the following:

1. Provide and appropriate explanation
2. Seek the individual's assent
3. Consider such persons' preferences and best interests
4. Obtain appropriate permission from a legally authorized person, if such substitute's consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, Dr. Antonio E. Puente will take reasonable steps to protect the individuals' rights and welfare (refer to APA, Ethical Principles of Psychologists and Code of Conduct, section 3.10, Informed Consent).

____

Printed, Full name of Client (or Authorized Representative*)

______________________________________ ___________________________

Client's Signature (or Authorized Representative*) Date

______________________________________ ___________________________

Witness' Signature Date

*If the authorization is signed by a personal, authorized representative of the patient, then a description of such representative's authority to act for the patient must be provided below:

____
____
____

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Wilmington, NC 28403
clinicalneuropsychology@gmail.com
Tele: 910.509.9371 Fax: 910.509.9372

Authorization for Release of Health Information

I, ____, ________________________ hereby authorize the
(print full name) (date of birth)

release of my health information from Antonio E. Puente, Ph.D. to the following recipients:

1. Name: ____
   Address: ____
   City/State/Zip: ____
   Telephone: ______________________________ Fax: ______________________________

2. Name: ____
   Address: ____
   City/State/Zip: ____
   Telephone: ______________________________ Fax: ______________________________

3. Name: ____
   Address: ____
   City/State/Zip: ____
   Telephone: ______________________________ Fax: ______________________________

(Please use the back of this form if more recipient space is needed.)

Purpose of disclosure (If you are a registered patient and do not desire to state a specific purpose, please write "at the request of the individual".):

____
____

Information Requested:

____
____

I understand and acknowledge that this may include the release of any information pertaining to alcohol/drug abuse, mental health, or HIV/AIDS.

I give my permission for the information listed above to be released to the above named recipient(s). I understand that I may revoke this authorization at any time, except to the extent that action has already taken place to comply with the authorization. This authorization will expire in 90 days after the date signed below. The recipient(s) of said information should not re-disclose any medical records to any third party without further written consent.

______________________________________ ______________________________
Client's Signature (or Authorized Representative) Date

______________________________________ ______________________________
Witness' Signature Date

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Informed Consent Form: Psychological/Neuropsychological Intervention

This document contains important information about Antonio E. Puente, Ph.D.'s intervention services. Please read and sign at the bottom to indicate that you have reviewed and understand this information.

Purpose:

The patient will undergo an intervention Program that may help reduce your symptoms.

Procedure:

The intervention process attempts to reduce your symptoms. The patient may be involved with the following:

- Psychotherapy – a one-on-one, verbal, therapeutic session that occurs once every week to every few months. Therapy may last up to several months or longer.

- Biofeedback – to reduce anxiety or pain, the patient may be trained with a computer to help with these issues. A trained technician, under the supervision of a licensed neuropsychologist, will perform this service.

- Cognitive Rehabilitation – to reduce a patient's problems with memory, the patient may undergo therapy with specific strategies to help improve it. A trained technician, under the supervision of a licensed neuropsychologist, will perform this service.

Goals of therapy will be set, however these may change over time.

Confidentiality:

Both North Carolina and the American Psychological Association Ethical Principles for psychologists require that all information disclosed during the evaluation is kept private and protected. Information that is shared will be kept strictly confidential and will *not* be disclosed without the patient's written consent. By law, however, confidentiality is not guaranteed in the following situations: (1) the patient directs me to tell someone else, in writing, (2) I determine that the patients is a danger to his or her self or to others, (3) I am ordered by the court of law to disclose the information, (4) I suspect that child abuse has occurred, and/or (5) the insurance company of the responsible party requests that information. If a patient is under the age of 18 years, their legal guardian must read and sign this form.

Complaints:

In the event that you are dissatisfied with my services for any reason, please do not hesitate to contact me and let me know. If you would like to submit a comment, concern, or complaint about our privacy practices, you can do so by sending a letter outline your concerns to:

Antonio E. Puente, Ph.D.
1508 Military Cutoff Road, Suite 303
Wilmington, NC 28403

If I am unable to resolve your concerns, you may report your complaint to the North Carolina Psychology Board at:

895 State Farm Road
Boone, NC 28607
(828) 262-2258

Freedom to Withdraw:

The patient has the right to end the evaluation at any time. If the patient wishes to do so, I am able to provide the names of other qualified professionals that may help in completing the evaluation.

Informed Consent:

I, the patient or legal guardian (if patient is under 18 years of age), have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I give consent for psychological/neuropsychological intervention.

I have discussed with Dr. Antonio E. Puente the various aspects of the intervention. This has included a discussion of the preliminary evaluation and diagnostic formulation, as well as the purposed method of treatment. The nature of this treatment has been described, including any possible side effects and possible alternative treatments.

____ ____________________________

Psychologist's Signature Date
Antonio E. Puente, Ph.D.

____ ____________________________

Client's Signature Date

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Informed Consent Form: Psychological/Neuropsychological Testing

This document contains important information about Antonio E. Puente's testing service. Please read and sign at the bottom to indicate that you have reviewed and that you understand this information in its entirety.

Purpose:

You, the patient, will undergo an evaluation that will help you to understand the relationship between behavior and nervous system functioning. The information obtained will help define the existing problem(s) and its trajectory as well as help in determining treatment options.

Procedure:

The testing process involves an interview (as well as possibly interviewing of others) and the completion of a variety of psychological testing. The total time of the evaluation may vary, and it will depend upon the questions that the patient being tested, the referral source for the testing, or that Dr. Puente or the test administrator may have. However, the time for the interview may be between one to three hours in length, and the time for the testing may be between three to six hours. Common features of evaluations typically include the following:

- Review of Relevant Records – background information that enables the evaluator to have a historical context that benefits the testing situation.
- Clinical Interview – the evaluation with the client contains (1) his or her background information, such as family history and past/present physical health, (2) mental health concerns, such as symptoms of distress, substance abuse, (3) educational, employment history, and a (4) mental/neurobehavioral status exam. Collateral contact may also be obtained to facilitate the process. The licensed neuropsychologist is the person who will perform the clinical interview.
- Testing – tests will assess cognitive ability as well as emotional status; these are either computerized or paper and pencil tests. Most tests are interactive and will be administered by a qualified and well-trained testing technician under the supervision of a licensed neuropsychologist.
- Validity Assessment – assessment of truthfulness based on the patient's presentation during the clinical interview, effort on testing exercises, and response patterns on the administered tests. It is *extremely* important that best effort is put forth and complete honesty is given at all times during the testing process.

Confidentiality:

Both North Carolina and the American Psychological Association Ethical Principles for psychologists require that all information disclosed during the evaluation is kept private and protected. Information that is shared will be kept strictly confidential and will *not* be disclosed without the patient's written consent. By law, however, confidentiality is not guaranteed in the following situations: (1) the patient directs me to tell someone else, in writing, (2) I determine that the patients is a danger to his or her self or to others, (3) I am ordered by the court of law to disclose the information, (4) I suspect that child abuse has occurred, and/or (5) the insurance company of the responsible party requests that information. If a patient is under the age of 18 years, their legal guardian must read and sign this form.

Complaints:

In the event that you are dissatisfied with my services for any reason, please do not hesitate to contact me and let me know. If you would like to submit a comment, concern, or complaint about our privacy practices, you can do so by sending a letter outline your concerns to:

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The patient has the right to end the evaluation at any time. If the patient wishes to do so, I am able to provide the names of other qualified professionals that may help in completing the evaluation.

Informed Consent:

I, the patient or legal guardian (if patient is under 18 years of age), have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I give consent for psychological testing.

I have discussed with Dr. Antonio E. Puente the various aspects of the evaluation. This has included a discussion of the preliminary evaluation and diagnostic formulation, as well as the purposed method of treatment. The nature of this treatment has been described, including any possible side effects and possible alternative treatments. I understand the limits to confidentiality, the scheduling policy, the fee policy, the policy regarding missed or cancelled appointments, and the emergency procedures.

______________________________________ __________________________

Psychologist’s Signature Date
Antonio E. Puente, Ph.D.

______________________________________ __________________________

Client’s Signature Date