MOUNT SINAI HEALTH SYSTEM **Joanne Festa, PhD**
Department of Neurology **Neuropsychologist**

Neuropsychological Evaluation Information Sheet

Be sure to arrive at the office **30 minutes prior** to the scheduled appointment time to complete your registration.

If you have downloaded and completed the intake forms (Initial visit, consent form, and registration sheet), please bring them with you and be sure to arrive **10 minutes prior** to the scheduled appointment time to complete your registration.

Preparing for neuropsychological evaluation:

- Get a good night's sleep.
- Eat an appropriate meal prior to your appointment.
- Feel free to bring water and/or a snack with you.
- Take all of your medications as usual unless you are directly instructed to do otherwise.
- If you use glasses, contact lenses, or hearing aids, make sure you have them with you.
- If you have had any neuropsychological, psychological, or academic testing done in the past, bring those records with you.

Your first appointment is for 3 hours. Unless otherwise discussed, you should bring a ***close family member or friend*** with you to your *first visit*. This person will be *needed for approximately 1 hour* of your appointment with the doctor **(after you complete the intake process).** This friend or family member will be included in your initial interview and help provide important information about you. Your family member or friend can leave after the interview process.

A neuropsychological evaluation is completely non-invasive. You will be asked questions, play games, solve puzzles, draw figures, and complete questionnaires about your feelings. Most people find the process interesting. Patients should not worry about whether they will "pass" or “fail” the exam. The assessment cannot be passed or failed; instead it describes how well a person performs relative to their peers.

As a courtesy to other patients seeking an appointment, if you are unable to keep your appointment, please **call us at least 72 hours in advance** and we will make every attempt to re-schedule your appointment.

If you have any questions, please feel free to call us at (212) 523-8060.

NEUROPSYCHOLOGY INITIAL VISIT

(PLEASE PRINT)

NAME: **DATE:**

DATE OF BIRTH: **AGE:**

Referring Physician: ___________________________

Did you bring a family member/friend with you? Yes No Name: _______________________________

Relationship to you: _________

Have you ever had neuropsychological assessment before? Yes No

If Yes, please provide year and provider: Year_____________ **Provider** __________________

Ethnicity: (Circle one)

African American **Caucasian/ White** **Other:** _______________________

Asian / Asian American **Hispanic**

American Indian/ Alaskan **Pacific Islander**

Education: (circle highest level)

1. Grammar school through 6th grade
2. Grammar school through 8th grade
3. Some High School (____ number of yrs)
4. Completed High School
5. Some College or tech. school (_____ number of yrs)
6. Bachelor's degree
7. Some graduate work (_______ number of yrs)
8. Graduate degree (_____ number of yrs)
9. Post-grad. degree (_____ number of yrs)

Handedness: (circle one) Right Left Ambidextrous

Areas of concern: What is the reason you came for a neuropsychological evaluation? (i.e., problems with memory, attention, concentration, declined performance at work, etc.)

When did these problems begin?

Are your current problems getting better, worse, or remaining the same?

Current Sleep: Do you have:

Sleep problems? Yes No

What amount of sleep do you get at night in hours ______________

Prolonged sleep onset Yes No

Do you require naps Yes NO

Mid-night awakening Yes No

How long do you nap _________

Early Morning Awakening Yes No

Do you take sleep medications? Yes No

Energy Level

Do you have decreased energy or fatigue? Yes/ No

If yes, how frequently? Daily, Weekly, etc ______________________________

Current Appetite

Unchanged __________

Weight change in last year? Yes/ No Gain / Loss

Increased __________

Amount in pounds: ______________

Decreased __________

Do you eat Breakfast? Yes __ No ___ Lunch? Yes __ No ___ Dinner? Yes __ No ___

Do you Exercise?

NO __________

YES _________

Type of exercise ______________________________

How often (ie, daily, weekly)_______________

Duration of exercise (in minutes) _________________

How would you describe your current mood? (ie, happy, sad, anxious)

Hall
SI
HI

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS INCLUDING VITAMINS AND HERBAL MEDS.

NAME OF MEDICATION	MILLIGRAMS PER TABLET	NUMBER OF TIMES PER DAY

How well do you follow your medication schedule?

Do you miss doses?

How often do you miss doses?

MEDICAL HISTORY

Developmental history: Was your birth uncomplicated/normal Yes NO

Were there any developmental difficulties (for example with walking or talking) Yes NO
Explain:

Please circle your medical diagnoses:

AIDS/HIV positive

Arthritis

Asthma/Bronchitis

Cancer (describe) __________________

____

Cardiac Arrest

Chronic Fatigue Syndrome

Concussion/ head injury

Diabetes

Epilepsy/ Seizure

Heart disease

Heart Attack/MI

High blood pressure

High Cholesterol

Hypoglycemia

Kidney disease

Liver disease

Lung disease

Lupus

Meningitis

Migraines

Multiple Sclerosis

Parkinson's disease

Polio

Stroke

Thyroid disease

Tumor

Other Disease/Disorder

____

Vision and Hearing

Do you require corrective lenses to see or read (eyeglasses or contact lenses)? Yes No

Do you require hearing aids? Yes No

Do you have: pacemaker defibrillator other device (explain) ______________________________

Do you experience any of the following (please circle):

Loss of vision
Double vision
Glaucoma
Cataracts

Urinary Frequency
Urinary Incontinence
Trouble with balance
Dizziness

Headaches
Migraines
Weakness

Trauma History: Have you ever been in an automobile/ motorcycle or other **accident**? Yes NO

What were your injuries?
____

Have you ever been knocked out, suffered a concussion, lost consciousness, or had a closed head injury? Yes No

Explain:

Toxin Exposure:
Have you ever had prolonged exposure to toxins such as lead, mercury, or solvents? Yes No

Explain:

Psychiatric History: Have you ever been treated by a psychiatrist? Yes No

Have you ever been in psychotherapy/counseling? Yes No

Have you ever been in a psychiatric hospital? Yes No

Do you smoke? Yes NO If Yes, how many packs per day ___________

Did you ever smoke? Yes NO If Yes, how many packs per day _________ For how many Years __________

Do you drink alcohol? Yes NO If Yes, how often? ________________ How many drinks_____________

Did you ever drink? Yes NO If Yes, how often? ________________ How many drinks_____________

Did you ever use recreational drugs? Yes No

Have you ever had an operation/surgery?	YES	If yes, please describe below.
	NO	

Operation/ Surgery Description	Date

Have you ever been hospitalized?	YES	If yes, please describe below.
	NO	

Reason for hospitalization	Date

FAMILY HISTORY		
Leave blank:		
Does anyone in your family have any neurological disorders?		
i.e. stroke, dementia, epilepsy, seizures, neuropathy, migraine, muscle disease, brain tumor		
Has anyone in your family had other significant medical conditions?	If yes, please describe below.	
i.e. diabetes, high blood pressure, heart attack, cancer, other serious conditions		

SOCIAL HISTORY
Where were you born (what city/state)? Where were you raised? Do you have siblings? Yes No If yes, how many? ___________
What schools did you attend? Public Private Parochial What were your average grades? Did you have learning difficulties/ need special help/ fail subjects? Yes No If yes, (explain): Did you graduate high school? Yes No Did you earn a GED? Yes No Did you attend college? Yes No If yes, what college/university? _______________________________ Circle the college degree/s you earned: Associates Bachelors Masters Medical PhD In what discipline? Do you have any hobbies (please list):
Are you currently working? Yes No If no, what is the reason for not working?
What has been your primary occupation?
Leave Blank
Did you ever serve in the Military? Yes No If yes, what branch? When did you serve? Where did you serve?

Current Living Situation/Marital Status:

√ check one: __ Single __Married __Divorced __Separated __Widowed __Domestic Partner __ Roommate

Please list additional physicians, addresses and phone numbers to whom you would like a copy of the office notes sent:

NAME	ADDRESS	PHONE #

IS THIS A NO FAULT CASE Yes NO

IS THIS A WORKERS COMP CASE YES NO

Are you currently involved in a lawsuit? Yes No

Explain:

Mt. Sinai Hospital

Dr. Joanne Festa

5 East 98th Street
New York, NY 10029

212-523-8060

Consent For Psychological/Neuropsychological Evaluation

I understand that the purpose of this evaluation is to provide information about me for my physician or other health care provider who has requested the evaluation in order to assist in their diagnosis and treatment of me. The material from the interview(s) and psychological/neuropsychological testing will result in the generation of a report that will provide information related to diagnosis and treatment of me. The report generated by Dr. Festa will be sent to my physician or other health care provider and Dr. Festa will also discuss the results of the evaluation with them. If desired by me or my referring provider Dr. Festa will also discuss the results with me and any others which I so designate by signing a release of information allowing Dr. Festa to do so. If this evaluation is being covered or partially covered by my insurance Dr. Festa may be required to provide the insurance company with a report as well.

Dr. Festa's questions will touch on personal and private matters that could cause me emotional discomfort and revive painful memories. I recognize that Dr. Festa has no intention of causing any personal discomfort but that she is simply carrying out her professional tasks associated with this evaluation. Even though some of the subject under discussion may not appear at first glance to have a direct connection with the issue at hand, I will cooperate to the best of my ability. I understand that although I am expected to give honest and accurate answers, I am free to refuse to answer any question I choose or to terminate the evaluation whenever I wish.

Dr. Festa is required to notify authorities if she knows of or suspects that a child is abused or if she has reason to believe that I may harm others or myself.

The terms of this evaluation has been reviewed, understood and agreed to by me.

Sign: ____ Date: ______________________________

____
(Please Print Name)

Guardian: ________________________________

Address: ________________________________
(Street)

____
(City & State)

____

Phone: ________________________________

Department of Neurology

We appreciate your cooperation in completing this form.
Once this form is complete, print it and bring it with you to your appointment.

Physician you are seeing: ❑ Dr. Joel Delfiner ❑ Dr. Shanna K. Patterson ❑ Dr. Joanne Festa ❑ Dr. Pojen Deng ❑ Dr. Lauren R. Natbony ❑ Dr. Huma Sheikh	**Appointment date**:

PATIENT INFORMATION

Last name:	**First**:	**Middle**:	
Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	**Birth date**:	**Sex**: ❑ M ❑ F	
Street address/PO Box:	**City**:	**State & Zip Code**:	
Email address:			
Cell/Mobile phone: ( )	**Home phone**: ( )	**Work Phone**: ( )	**Ext**:
Employer Name:	**Employer Address**:	**Occupation**:	
Pharmacy Name:	**Pharmacy Address**:		
Pharmacy Phone: ( )	**Pharmacy Fax**: ( )		

REFFERAL SOURCE

Referring Source (Please check all that apply): ❑ Physician/Clinic ❑ Family/friend ❑ Clergy ❑ Employer/Coworker ❑ 800-MD-SINAI ❑ Mount Sinai Website ❑ Insurance ❑ No Referring MD ❑Self ❑ **Other**:

❑ *Check if this is a **second opinion***

Referral Name:	
Referral E-mail:	
Referral Address:	
Referral Phone: ( )	**Referral Fax**: ( )

INSURANCE INFORMATION

(Please present your insurance card to the receptionist.)

Person responsible for bill: ❑ Self	**Birth date**: / /	**Address** (if different):	**Home phone no.**: ( )
Occupation:	**Employer**:	**Employer address**:	**Employer phone no.**: ( )
Name of primary insurance:			
Subscriber's name: ❑ Self	**Birth date**:	**Group no.**:	**Policy no.**:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

SECONDARY INSURANCE (IF APPLICABLE)

Name of secondary insurance:	**Subscriber's name**:	**Group no.**:	**Policy no.**:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY		
Please notify in case of emergency:	**Relationship to patient**:	
❑ Check if address is the ***same*** as in patient information		
Address:	**City, State**:	**Zip**:
Home phone: ( )	**Work/cell phone**: ( )	

OTHER TREATING PHYSICIANS		
Primary Care Physician:		
Address:		Phone: ( )
Fax: ( )	Conditions Treated:	
Specialist Physician(s):		
Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize the ***Department of Neurology*** and/or insurance company to release any information required to process my claims.

Patient/Guardian signature:		**Date**:
Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Drs. ______________ __________________________ (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website, can be provided to me upon request, and may be posted in the office.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though they may be employed by, contracted by, or affiliated with Mount Sinai Health System hospitals or facilities. I understand that I can determine the health plans participated in by physicians who are employed by, are contracted by, or are affiliated with Mount Sinai Health System hospitals or facilities by visiting http://www.mountsinai.org/patient-care/find-a-doctor . I also understand that I can determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting those facilities' web portals at www.mountsinaihealth.org/insuranceinfo

I understand that laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services provided in connection with my care may not be billed by the Physicians, and may be billed separately by the laboratories/facilities/providers who provide those services (even if those services are provided by Mount Sinai Health System facilities, laboratories, or providers). I further understand that laboratories/facilities/providers who provide laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services may or may not be participating providers in my health care plan network, that I can obtain the contact information for any such laboratories/facilities/providers whose services may be needed in connection with my care from the Physicians, and that I can contact those laboratories/facilities/providers directly to obtain information regarding their health plan participation.

I understand that if I elect or choose to obtain services from a provider who I know or who has been disclosed (in writing, on a website, and/or at the time my appointment was made) as not participating in my health plan network, I will be responsible for any and all charges billed by that provider to me. I further understand that if the Physicians do not participate in or with my health plan and/or network, the amount or estimated amount that the Physicians will bill for healthcare services can be made available to me in advance, upon request.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

______________________________	______________________________
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE	DATED
______________________________	______________________________
RELATIONSHIP TO PATIENT	WITNESS TO SIGNATURE

7/15/2015

Ambulatory Patient Notification Record

I acknowledge that I have been given the following Notices and forms, as required by State and Federal regulations where appropriate:

- New York State Patient's Bill of Rights
- New York State Parent's Bill of Rights
- Patient's Responsibilities
- Notice of Privacy Practices
- Health Information Exchange (HIE) and Healthix Consent Form
- An Important Message From Medicare About Your Rights
- New York State Health Care Proxy Form
- Summary of Policy on Advance Directives
- Patient Information on Pain Management
- Appendix & Glossary

By signing below, I acknowledge that I have been provided a copy of the aforementioned Notices and Appendixes, when applicable, and have therefore been advised about my rights and responsibilities as a patient, any options available to me regarding advance directives, of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

____
Print Name of Patient or Personal Representative

_______________________________________ ___________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the foregoing Notices upon registration because:

- ○ The patient refused to sign, despite good faith efforts;
- ○ The patient was unaccompanied and not alert or oriented;
- ○ The patient was unaccompanied and needed emergency care;
- ○ Other: ____.

Employee signature: __________________________ Employee Title: ______________________

Print Name: __________________________________ Date: _______________________________

Mount Sinai Health Information Exchange (HIE) and Healthix Consent Form

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called e-health or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect.org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants on the website will be updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of The Mount Sinai Hospital and Icahn School of Medicine at Mount Sinai (together, "Mount Sinai") to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization ("RHIO"), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE.

PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION

Your Consent Choices. You can full out this form now or in the future. You have the following choices:
Please check Box 1 or Box 2.

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of my electronic health information through the Mount Sinai HIE and I GIVE CONSENT TO ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.**

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access my electronic health information through the Mount Sinai HIE and I DENY CONSENT TO ALL employees, agents, and members of the medicals staff of Mount Sinai to access ANY of my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.**

Note: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will only be shared in an emergency as allowed by applicable law.

______________________________	______________________________
Print Name of Patient	Patient Date of Birth
______________________________	______________________________
Signature of Patient or Patient's Legal Representative	Date
______________________________	______________________________
Print name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)