



# Flint Hills Neuropsychology

2505 Anderson, Suite 101  
Manhattan KS 66502-2853  
tel: 785-236-1180/fax: 785-789-4048  
flinthillsneuropsych.com

## New Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ (Circle: Home Work Cell Other contact: \_\_\_\_\_)

Phone: \_\_\_\_\_ (Circle: Home Work Cell Other contact: \_\_\_\_\_)

Phone: \_\_\_\_\_ (Circle: Home Work Cell Other contact: \_\_\_\_\_)

Email address: \_\_\_\_\_

Employer (or if a student, list school, year/grade, and degree program):  
\_\_\_\_\_

May we call you at these numbers? (Y/N): Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

May we leave a voicemail? (Y/N): Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

What is your preferred method for appointment reminders? (circle) Email Text Phone call

Occupational Status:

\_\_\_\_\_ Full-time student

\_\_\_\_\_ Part-time student

\_\_\_\_\_ Homemaker

\_\_\_\_\_ Retired

\_\_\_\_\_ Disability

\_\_\_\_\_ Unemployed

\_\_\_\_\_ Part-time employed

\_\_\_\_\_ Full-time employed

Occupation/Job title:

\_\_\_\_\_

Education:

\_\_\_\_\_ Years Completed

\_\_\_\_\_ Highest Degree

Handedness (circle):

Right/Left/Ambidextrous

Marital Status:

\_\_\_\_\_ Single

\_\_\_\_\_ Live-in/partnered

\_\_\_\_\_ Married

\_\_\_\_\_ Separated

\_\_\_\_\_ Divorced

\_\_\_\_\_ Widowed

Ethnicity:

\_\_\_\_\_

Briefly describe the symptoms you are having and when they began:

---

---

Are these symptoms the result of an injury? Yes \_\_\_ No \_\_\_ If so, date of injury: \_\_\_/\_\_\_/\_\_\_

Was it a motor vehicle accident? Yes \_\_\_ No \_\_\_ Were you injured at work? Yes \_\_\_ No \_\_\_

Are you represented by an attorney? Yes \_\_\_ No \_\_\_ If so, name of attorney: \_\_\_\_\_

**Health History**

Please list your current treating physicians:

PHYSICIAN

SPECIALTY

---

---

---

Please list the names and dosage of any prescription or non-prescription medication you are currently taking including vitamins, herbals, or supplements (or, you may bring a separate list):

MEDICATION

DOSAGE

---

---

---

---

---

---

---

---

---

---

Indicate any chronic medical conditions or prior surgeries/hospitalizations:

---

---

---

List any prior mental health or substance abuse problems or treatment history:

---

---

List any head injuries or concussions with dates:

---

---

**Emergency Contact:** Please list an adult we may call in case of an emergency.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have a legal guardian, conservator, or power of attorney? \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Health Insurance**

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Insurance I.D. Number: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Policy holder's name as it appears on the card: \_\_\_\_\_

Policy holder's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's relationship to policy holder: \_\_\_\_\_

**Secondary Health Insurance**

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Insurance I.D. Number: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Policy holder's name as it appears on the card: \_\_\_\_\_

Policy holder's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's relationship to policy holder: \_\_\_\_\_

**For those not using insurance:**

Will you be paying for the fees yourself or will they be paid by another responsible party?

Self-pay: \_\_\_\_\_

Other (name and contact information): \_\_\_\_\_  
\_\_\_\_\_

**Informed Consent & HIPAA Acknowledgment**

Please **initial** each statement and sign at the bottom of the page.

1. \_\_\_\_ I grant permission to release any required information and reports to my insurance company in order to process my claims for services. Additionally, I authorize payment of medical benefits to the supplier of services. I also understand that I am responsible for any fees not covered by my insurance company. (required only if you will be using insurance benefits for payment)
  
2. \_\_\_\_ I have reviewed the Informed Consent & HIPPA document offered to me and/or that is available online (<http://www.flinthillsneuropsych.com>) and I understand my rights and responsibilities.
  
3. \_\_\_\_ I understand that there is a \$250 fee billed directly to me for testing sessions that are missed or canceled with less than 72 hours notice, and a \$45 fee billed directly to me for any other sessions that are missed or canceled with less than 24 hours notice (such as psychotherapy or feedback sessions).

Signed \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name (Please Print): \_\_\_\_\_