CARDINAL
CLINICAL CONSULTING

Thank you for your interest in the services of Cardinal Clinical Consulting, LLC.

The paperwork is required for all new patients. Once this packet is completed, you can return it to our office by mail, fax, or email. If you have any questions about the information in this packet, feel free to contact the clinic at (662) 269-3599. To return this packet, either:

Mail to:

Cardinal Clinical Consulting
P.O. Box 3897
Tupelo, MS 38803

Fax to:

662-269-2503

Scan / email to:

info@cardinalclinical.com

Our physical address:

Cardinal Clinical Consulting
2625 Traceland Drive, Suite B
Tupelo, MS 38801

Once you arrive at this address, you should see Elite Medical and SouthernCare Hospice Services; the entrance to our office is located on the left-hand side of the building. A sign with our logo should be visible. You may park alongside the building in a designated parking space or in the lot located behind the building.

Cardinal Clinical Consulting
662-269-3599

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New Client Information

Today's date: ___/____/____

Client information

Name: _____
(First) (Middle) (Last)

Date of birth: ___/____/_____ **Age: _____** **Sex:** ☐ Male ☐ Female

Preferred name? _____ **Preferred Pronouns:**

Ethnicity: ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino
☐ Native American ☐ White/Caucasian ☐ Other:

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home phone: (___) ____-_____ **Cell: (___) ____-____** **Work phone: (___) ____-_____**

Email: _____

Preferred method of contact: (Circle)

Home phone Cell phone

Work phone Email

May we leave a message on your answering machine? ☐ No ☐ Yes

Insurance Information

Insured's Name: _____ **Insured's D.O.B.:** ____/____/_____

Insurance Plan Information:_____
Please bring your card to the appointment Company Group/Policy # Member ID

Referral Information

Who referred you to us? If you found us on your own, please list where you heard about us.

Name: _____

Phone number: (____) _____-_____ **May we contact this person?** ☐ Yes ☐ No

How do you know this person?

☐ Physician/pediatrician ☐ Relative ☐ Friend ☐ School staff

☐ Mental health provider ☐ Internet/Online ☐ Other: _____

What are your current reasons for this evaluation?

Are there any problems you are experiencing that you would like help with?

Have you been tested or diagnosed previously? If so, please list below and provide copies of any evaluation results.

Diagnosis (e.g., ADHD, Learning Disability, etc.)	When was it made?	Who made it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Information

Primary Care Physician:

Name: _____ Specialty: □ General practice

Address:_____ □ Other: _____

_____ Phone: (___) ____ - _____

Medical History:

Do you take medication? □ Yes □ No

If yes, please provide the name of the medication, the dosage, and the prescriber.
If more room is necessary, please attach a separate page.

Do you have any known drug allergies? □ Yes □ No

If yes, please indicate:

Have you ever been hospitalized? □ Yes □ No

If yes, please describe why and include age/time of hospitalization:

Have you ever had surgery? □ Yes □ No

If yes, please describe the reason for surgery and your age when it occurred:

Have you ever had a seizure? □ Yes □ No

Please check any condition or symptoms that you have experienced:

□ Allergies	□ Colic	□ Head injuries	□ Rashes/eczema
□ Anemia	□ Constipation	□ Heart problems	□ Reflux
□ Apnea	□ Convulsions/seizures	□ Measles	□ Spina bifida
□ Asthma	□ Diabetes	□ Meningitis	□ Staring spells
□ Brain infection	□ Diphtheria	□ Mumps	□ Stomach problems
□ Broken bones	□ Eye problems	□ Obesity	□ Swallowing issues
□ Cerebral palsy	□ Fainting spells	□ Pneumonia	□ Tics/twitches
□ Chicken pox	□ Frequent diarrhea	□ Poisoning	□ Tonsillitis

Please explain any problems indicated above or other medical issues experienced below or on a separate page:

Medical Information (continued)

Have you ever seen any of the following specialists? (Check all that apply)

☐ Gastroenterologist ☐ Neurologist ☐ Psychiatrist ☐ Geneticist

☐ Feeding specialist ☐ Cardiologist ☐ Other: _____

Please describe the reason for visit and any relevant results:

Family Medical History

If any of your biological relatives have had any of the following conditions, please check the box next to the condition and write that person's relationship to you (e.g., uncle – mother's side) next to it.

Condition	Relationship	Condition	Relationship
☐ Autism Spectrum Disorder		☐ Alcohol/Drug abuse	
☐ Intellectual disability		☐ Birth defects	
☐ Developmental delay		☐ Cerebral palsy	
☐ Speech/language disorder		☐ Suicide	
☐ ADHD		☐ Depression	
☐ Learning Disability		☐ Anxiety disorders	
☐ Birth defects		☐ OCD	
☐ Seizures or epilepsy		☐ Bipolar disorder	
☐ Tourette's disorder/Tics		☐ Schizophrenia	
☐ Rett's Disorder		☐ Cancer	
☐ Other/more information:			

Educational History

Are you currently in school? ☐ No ☐ Yes, at: _____Grade:_____

Highest grade completed? _____

Have you ever had difficulty academically? ☐ No ☐ Yes:

Please explain:

Did you ever have to repeat a grade? ☐ No ☐ Yes:

Additional Information

Are you currently employed? □ No □ Yes:

Employer:_____

Job Title: _____

Have you ever received any adjunctive services, such as:

□ Special instruction □ Speech therapy □ Occupational therapy □ Physical Therapy

□ Counseling/Therapy □ Other:_____

If yes, please indicate where and when you received these services, and if they are still ongoing:

Please include any other information you believe is relevant for your evaluation.

Thank you for completing this information! Please read and sign the following pages regarding the clinic's policy and procedures.

No-Show and Cancellation Policy

Appointments may be rescheduled if advance notice is given and alternative appointment times are available. A missed or cancelled appointment is disruptive to the operation of the clinic, and it impacts the psychologist, the client, and other clients who could have potentially utilized that time slot. As a result, a fee of **$200** will be charged in the event of a no-show or late cancellation.

A "no-show" is missing a scheduled appointment without any notification prior to the scheduled appointment time. A "late cancellation" is cancelling an appointment within 24 hours of the scheduled appointment time. This means that if an appointment is scheduled for 9:00 a.m. on a Thursday, you must cancel your appointment by calling or emailing our clinic by 9:00 a.m. on Wednesday (please note: a Monday appointment must be cancelled by the Friday before the appointment). Consideration of extraordinary circumstances may occur on a case-by-case basis.

Clients who no-show for an appointment will NOT be automatically rescheduled. If the client initiates a phone call requesting to be rescheduled after a no-show, they may first be returned to the waiting list.

No-show/late cancellation fees are the full responsibility of the client.

By signing below, you are agreeing to the terms of this policy and you acknowledge your responsibility in making scheduled appointments.

_____ _____

Printed name of person completing this form Date

_____

Signature

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal representative.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases further risk.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another

licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION.

_____ _____

Printed name Date

_____

Signature

Consent for Psychological Services and Clinic Policies

This document contains important information about my professional services and business policies. Please read it carefully and feel free to ask any questions you may have.

This agreement indicates that I, Dr. Joshua C. Fulwiler, will provide psychological testing and/or assessment services to _____. I am a fully licensed psychologist. This form is to document any consent for assessment and/or treatment as well as an agreement to the conditions of the assessment and/or treatment.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when there is evidence that:

- Patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform appropriate individuals about how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I may be required to inform the person who is the target of the threatened harm and the police.
- Patients tell me, or I otherwise learn that, it appears that a child or elderly person is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state protective agency.
- I am ordered by a court to disclose information. In this circumstance, I will notify you before complying with any court-ordered release of information.

Please initial on the following line to indicate your understanding of these limits of confidentiality.

INITIALS: _____

Nature of Psychological Assessment

The assessment may consist of interviews, surveys, educational tests and/or psychological tests. Areas to be assessed may include intellectual, adaptive, academic, social and emotional functioning. The results from this assessment and the written report will not be shared with anyone unless you give explicit permission for such a release of information.

Many people find psychological assessment to be an interesting and enjoyable experience. It is generally thought of as a benign procedure; however sometimes people can be disappointed or unsettled by the results. In addition, any discussion of problems may bring about some emotional strain or distress. You are welcome and encouraged to discuss with the evaluator any questions

that you have regarding the assessment. The practice of psychological services is not an exact science and so predictions of its benefits, outcomes or duration are not precise or guaranteed.

Please initial on the following line to indicate your understanding about the nature of this evaluation.

INITIALS: _____

Professional Fees and Billing

My hourly rate is $200. Normally, a psychological evaluation takes anywhere from 6 to 10 hours and usually costs about $1500.00. This includes the time for testing, scoring, interpretation, report writing, and feedback sessions. A copy of the report will only be provided when your account is in good standing. You may suspend the evaluation at any time, but you will still be responsible for timely payment of those services rendered prior to the ending of the assessment. Payment may be in the form of cash, any major credit card, or a personal check made out to Cardinal Clinical Consulting, LLC.

If your account has a balance due after 60 days, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

Some insurance plans may reimburse you for some portion of your costs for an out-of-network provider. If you wish to file a claim with your insurance company, I will provide you with an itemized invoice (a "Superbill") that includes the basic information requested by most insurance companies, including the services rendered, amount paid, diagnostic information/results, and the billing codes used.

Please initial on the following line to indicate your understanding of the clinic's fees and billing.

INITIALS: _____

Insurance Reimbursement

I am an in-network provider for most private insurance plans, as well as Mississippi Medicare and Medicaid. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. My authorized representative will fill out and submit claims to your plan to provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You are responsible for all payment of any fees not covered by your insurance plan, which may be in the form of a co-payment, a co-insurance amount, or the remainder of your plan's deductible. If you send your insurance information prior to your appointment, we will verify your benefits and provide an estimate of your expected costs.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be

happy to help you in understanding the information you receive from your insurance company. Due to the rising costs of health care, insurance benefits have increasingly become more complex, and every plan treats mental health benefits differently.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. You understand that, by using your insurance, you authorize me to release such information to your insurance company. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

If you have another insurance plan, they may reimburse you for some portion of your costs for an out-of-network provider. If you wish to file a claim with your insurance company, I will provide you with an itemized invoice (a "Superbill") that includes the basic information requested by most insurance companies, including the services rendered, amount paid, diagnostic information, and the billing codes used.

Please initial on the following line to indicate your understanding of insurance reimbursement and to agree to release your information to your insurance company by me or my authorized agent.

INITIALS: _____

Contact

I am often not immediately available by telephone. Though I am usually in my office daily, I do not have an office manager and cannot answer my phone when I am with a patient. When I am unavailable, my telephone is answered by an answering machine. I will make every effort to return your call as soon as possible. If you have an extremely urgent matter, contact your family physician or the nearest emergency room and ask for the psychologist on call. **In the event of an emergency, always call 911.**

Please initial on the following line to indicate your understanding of the contact agreement.

INITIALS: _____

By signing below, you indicate that you have read this document and agree to abide by its terms during our professional relationship.

Signature _____ Date_____