ATHENS NEUROPSYCHOLOGY AND COUNSELING

Matt F. Butryn, Ph.D., LLC

Clinical Neuropsychologist

Pediatric, Adult, and Forensic Psychology

Patient Name: ________________ ________________ ___________________ **Date of Birth**: ____________ **Age**: _________
First Middle Last (mm/dd/yyyy)

Nickname: ________________ ❑N/A **Gender**: ❑M ❑F **Marital Status**: ❑Married ❑Separated ❑Single ❑ Widowed

Parent/Guardian (if patient is a minor) Name:_______________________________________

Patient Employment Status: ❑Employed ❑Unemployed ❑Disabled ❑Retired ❑Full-Time Student ❑Part-Time Student

HIPAA Agreement: You must agree to and sign our HIPAA and Consent Forms attached to this documentation for us to see you.

Referring Provider/Agency: ______________________________ _____________________ __________________
Name Relationship Phone

Primary Care Doctor: ______________________________ _____________________
Name Phone

Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes

PCP Release: ❑I, as patient/parent/guardian, consent to Dr. Butryn releasing information to my PCP and Referring Provider
❑I, as patient/parent/guardian, do not consent to Dr. Butryn releasing information to my PCP and Referring Provider
Initial information released to your PCP and Referring Provider may include a general statement notifying them of your visit, will be limited to a brief description of the problem area and/or diagnosis, may include a general outline of treatment, and will be used for coordination/continuity of care.

Home Address: _______________________________
Address Line 1
____
Address Line 2
____________________ _______ ___________
City State Zip Code

Mobile Phone: ___________________ ❑No Messages ❑Voice Messages OK ❑Text Messages OK ❑Voice & Text Messages OK

Home Phone: ___________________ ❑No Messages ❑Voice Messages OK

Work Phone: ___________________ ❑No Messages ❑Voice Messages OK

Other Phone: ___________________ ❑No Messages ❑Voice Messages OK ❑Text Messages OK ❑Voice & Text Messages OK

****Preferred Phone****: ❑Mobile Phone ❑Home Phone ❑Work Phone ❑Other Phone

Appointment Reminder Calls: We will call to remind you of your appointment 48 hours prior to the appointment. Please note, the automated reminder call will come from the following phone number-(202) 471-1508.

E-mail Address: ____

By providing your e-mail address, you are giving ANC permission to communicate with you through e-mail. This includes but is not limited to receiving your results and other materials via email. You acknowledge and accept the risks inherent in such communication. _______Initial

Emergency Contact: ______________________________ _____________________ __________________
Name Relationship Phone

Emergency Contact: ______________________________ _____________________ __________________
Name Relationship Phone

www.athensbrain.com

1 Huntington Rd., Ste. 802 Athens, GA 30606 Phone. 706.548.0018 Fax. 706.548.2389

Brief Health Summary

Accident/Injury Information

Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please complete:

Date of accident:	
Type of Accident:	❑Auto ❑Work ❑Home ❑Other:
Report of accident made to:	❑Auto Insurance ❑Employer ❑Workers Comp ❑Other:
Auto Insurance Carrier:	
Workers Comp. Carrier:	
Adjustor:	
Attorney:	

Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:

Medical/Physical Conditions

Name of Condition/Problem	Since When/Beginning Date	Treated With/By

Mental/Emotional Conditions

Name of Condition/Problem	Since When/Beginning Date	Treated With/By

Medication List

Name of Medicine	Dosing (How Much/When Taken)	For What

Surgeries/Hospitalizations (Medical & Psychiatric)

Type of Surgery/Hospitalization	Name of Facility/Hospital	Date

Consent for Disclosure to Family Member and/or Personal Representative

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Dr. Butryn/Athens Neuropsychology & Counseling, doctors and staff to disclose my personal medical information to the following individuals:

______________________________	________________
Name	Relationship
______________________________	________________
Name	Relationship
______________________________	________________
Name	Relationship

Conditions for Disclosure:

- ❑ The practice may disclose my personal health information to the individual(s) above **only** in my presence.
- ❑ The practice may disclose my personal health information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, fax, email, and regular mail.
- ❑ Other conditions of disclosure: ______________________________

I understand that this consent is in effect until revoked by me by written notice to the practice.

____ ________________

Signature of patient or his or her personal representative Date

____ ________________

Printed name of patient or personal representative Relationship to the patient

____

Description of personal representative's authority

____

Signature of authorized representative of this office or practice

Insurance Information:

Insurance Carrier's Name: ____________________ Insurance Carrier Phone No.:____________________

Member ID Number: ____________________ Member Group No.: ____________________

Name of Primary Insured: ____________________ Primary Insured's SS#____________________

Primary Insured's Relationship to Patient: ____________________ Primary Insured's Date of Birth (mm/dd/yyyy): ____________

Primary Insured's Employer: ____________________ Primary Insured's Work Phone: ____________________

Primary Insured's Home Phone No.: ____________________ Primary Insured's Mobile Phone No.: ____________________

Primary Insured's Address:

____

Street City State Zip Code