REGISTRATION FORM

CLIENT INFORMATION

Today's Date:	**PCP:**	**PCP Clinic**:
Client's Last Name:		Is this client's legal name? □ Yes □ No
First Name:	Middle Initial:	Legal Name if applicable:
Client's Date of Birth:	Client's Age:	Client's Sex: □ Male □ Female
Street Address:		
P.O. Box:	City:	State: Zip Code:
Home Phone: ( )	Cell: ( )	Email:
Occupation:		Employer/School:
Employer Phone Number: ( )	School (if applicable):	

Chose clinic because/referred to clinic by (Please check one box):

□ Dr. □ Family □ Friend □ Insurance Plan □ Hospital □ Close to home/work □ Internet □ Other

GUARDIAN INFORMATION

(Please complete if client is under 18 or under guardianship)

Guardian's Name:	Date of Birth:	Relationship to Client:
Who has custody?	Does the client live with the guardian? □ Yes □ No	
Guardian Email:	How do you prefer to be contacted: □ Cell □ Home # □ Work □ Email	

INSURANCE INFORMATION

(Please give your insurance card and driver's license to receptionist)

Person responsible for bill:			Relationship to Client:		
Address of this person (if different):					
Phone Number: ( )			Is Client covered by Insurance? □ Yes □ No		
Please indicate **PRIMARY** insurance:		□ **AR Blue Cross**	□ **Anthem Blue Cross**	□ **Blue Cross Out of State**	
□ **Cigna Health**	□ **United**	□ **Qualchoice**	□ **Health Advantage**	□ **Tri-Care**	□ **Aetna**
□ **ARKids A**	□ **ARKids B**	□ **Medicaid**	□ **TEFRA**	□ **Other**_____	
Subscriber's Name:					
Subscriber's Date of Birth:			Subscriber's Social Security #:		
Member ID#:			Group Number:		
Relationship to Client: □ Self □ Spouse □ Parent/Guardian □ Other					

Is there a **SECONDARY** insurance?	□ Yes □ No	If so, which company?
Subscriber's Name:		Member ID#:
Subscriber's Date of Birth:		Subscriber's Social Security #:
Relationship to Client: □ Self □ Spouse □ Parent/Guardian □ Other		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize Conway Psychological Assessment Center or the insurance company to release any information required to process my claims.

_____ _____

Client/Guardian signature *Date*

4206 Prince Street., Conway, Arkansas 72034 (501) 932-0255
www.conwaypsychtesting.com

CLIENT* RIGHTS AND RESPONSIBILITIES **CLIENT'S NAME:** _____

1. The client has the right to expect appropriate psychological care regardless of race, disability, color, religion, national origin, the client's source of payment, sexual orientation, or religious and spiritual beliefs.
2. The client has the right to be treated with respect, addressed by proper name without undo familiarity, listened to when requesting information and to receive an appropriate and timely response.
3. The client has the right to privacy and confidentiality in all aspects of care. The client's records will be treated as confidential. The client is entitled to privacy when examined – to have the door closed, to have observers identified, and to be informed of the role they play in client care. The client may ask any individual to leave the room, and has the right to restrict visitors during the assessment or consultation.
4. The client has the right to an explanation of all charges.
5. The client has the right to know the name of the clinician responsible for his/her service, to talk with that clinician and to obtain information necessary for an understanding of his/her problems.
6. The client has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for care) concerning treatment with the expectation that the clinic will honor the intent of that directive to the extent permitted by law and policy.
7. The client has the right to be informed of the course of the assessment and to receive an explanation of any planned procedures. If an interpreter is required, one will be obtained for the client.
8. The client has the right to refuse a service.
9. The client has the right to be advised when the clinician is considering the client as part of a clinical research program, and the client must give informed consent prior to actual participation in such a program. After the details of the program have been explained, the client may refuse to participate and may cancel participation at any time. This decision will not change the right of the client to receive treatment.
10. **The client has the right to express any grievance orally or in writing, without fear of reprisal. The client has the right to discuss their concerns with their doctor or therapist or they may bring their concerns to the C-PAC Clinical Director at 501-932-0255 or 501-932-0263**.
11. The client has the right to obtain a personal advocate at any time.

CLIENT RESPONSIBILITIES

1. The client has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to psychiatric health.
2. The client has the responsibility to report unexpected changes in his/her condition to the responsible practitioner. The client is responsible for reporting whether he/she comprehends a contemplated course of action and what is expected of him/her.
3. The client is responsible for following the treatment plan recommended by the practitioner primarily responsible for his/her care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, and implement the responsible practitioner's orders. The client is responsible for his/her actions if he/she refuses treatment or does not follow the practitioner's instructions.
4. The client is responsible for keeping appointments, and when the client is unable to do so for any reason, is responsible for notifying the responsible practitioner.
5. The client is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.
6. The client is responsible for following C-PAC rules and regulations affecting client care and conduct.
7. The client is responsible for being considerate of the rights of other clients and C-PAC personnel and for assisting in the control of noise and by not smoking. The client is responsible for being respectful of the property of other persons and C-PAC.

*The term client includes, when appropriate, the family, guardian or primary caregiver.

I have read this statement of rights and responsibilities and/or it has been read to me. I have had an opportunity to ask questions and have them answered. I understand what my rights and responsibilities are, and I have been given a copy of this statement.

_____

Client/Parent/Guardian's Signature **Date**

_____

Relationship of Signer

Intake Form

Please Complete as fully as possible

For the purposes of communication, "Client" is used to denote the person for whom treatment or assessment will be provided

Client's Name		**Date**	
Client's Gender		**Client's Ethnicity/Race**	
Mailing Address		**City/State/Zip**	
Client's Date of Birth		**Client's Age**	
Guardian's Name		**Guardian's Date of Birth**	
Client/Guardian's Phone		**Email Address**	
Emergency Contact		**Relationship to Client**	
Primary Care Physician		**PCP Clinic**	
Current Therapist (if has one)		**Current Psychiatrist**	
Who referred you to us?		**Relationship to Client**	
Client/Guardian's Employer		**Occupation**	
School:		**Grade/Classification:**	
Teacher (If client is a child):		**Teacher's Email:**	

Section A: To be completed for testing and therapy clients

Please use this space to describe/explain the purpose of this visit (include symptoms, frequency, and how long present).

Purpose of this visit (Select all that apply)

☐ **Therapy**	☐ **Educational/Dyslexia Testing**
☐ **Psychological Testing to help with current treatment**	☐ **Psychological Testing before getting treatment**
☐ **Bariatric Surgery Psychological Evaluation**	☐ **Spinal Stimulator/Pain Treatment**
☐ **Disability Claim**	☐ **Qualify for waiver Services**
☐ **Other:**	

Other information that we should know as we start psychotherapy/psychiatric services or testing/assessment:

What would you like to see happen as a result of these services?

Section B: To be completed for testing and therapy clients

Symptoms

☐	Loss of interest	☐	Poor concentration/memory	☐	Thoughts of regret, self-hatred, & suicide
☐	Loss of appetite	☐	Lack of sleep	☐	Inability to memorize
☐	Confusion	☐	Mood swings (minute by minute)	☐	Poor grammar when speaking (His is thirsty)
☐	Arguing with others	☐	Irritability	☐	Aggression toward adults
☐	Dreading work/chores	☐	Avoiding huge public places	☐	Aggression toward peers
☐	Rejecting affection	☐	Panic Attacks	☐	Feeling of helplessness/hopelessness
☐	Detachment from real world	☐	Not able to make decisions	☐	Lack of emotions or impulses
☐	Poor personal hygiene	☐	Loss of motivation	☐	Social withdrawal
☐	Inability to fall asleep	☐	Inability to remain asleep	☐	Waking up too early
☐	Upsetting nightmares/dreams	☐	Night terrors	☐	Feeling of a bad future
☐	Checking (as a ritual)	☐	Low self-esteem	☐	Fear of embarrassment
☐	Counting (as a ritual)	☐	Excessive weight gain	☐	Excessive weight loss
☐	Exercising excessively	☐	Refusal to eat or skipping meals	☐	Washing hands repeatedly
☐	Fidgeting a lot	☐	Forgetting names, important dates	☐	Creating physical symptoms for attention
☐	Hoarding objects	☐	Lack of eye contact	☐	Lack of conversation & speech
☐	Initiating fights	☐	Doesn't pick up on social cues	☐	Being unaware of feelings & emotions
☐	Insisting upon rituals	☐	Repetitive body movements	☐	Extremely sensitive to touch, light/sound
☐	Interrupting others	☐	Fear of contamination (dirt)	☐	Difficulty transitioning
☐	Poor social skills	☐	Expects excessive orderliness	☐	Abnormal body movement/coordination
☐	Talking excessively	☐	Hearing voices not there	☐	Easily influenced/Follower
☐	Fearing abandonment	☐	Lacking focus	☐	Inability to make or keep friends
☐	Violent behavior	☐	Disorganization	☐	Inability to make/maintain eye contact
☐	Fearing dying	☐	Persistent lying	☐	Violating rules and regulations
☐	Feeling of being alone	☐	Obsessing over symmetry	☐	Restricted interests
☐	Restricted interests	☐	Excessive daytime sleepiness	☐	Suicidal thoughts/Self-harm (cutting)
☐	Attention seeking	☐	Thinking of death/suicide	☐	Frequent psychiatric hospitalizations
☐	Hallucinations	☐	Delusions	☐	Excessive video game playing
☐	Creating dramatic stories	☐	Will only eat certain colored food	☐	Extremely bothered by certain textures
☐	Plays with feces	☐	Extreme elevation in mood	☐	Will only eat high fat/carbohydrates
☐	Other:				

List the most significant symptoms	**Frequency**
	☐ Daily ☐ Weekly ☐ Monthly ☐ Every few months ☐ A few times a year
	☐ Daily ☐ Weekly ☐ Monthly ☐ Every few months ☐ A few times a year
	☐ Daily ☐ Weekly ☐ Monthly ☐ Every few months ☐ A few times a year
	☐ Daily ☐ Weekly ☐ Monthly ☐ Every few months ☐ A few times a year
	☐ Daily ☐ Weekly ☐ Monthly ☐ Every few months ☐ A few times a year
	☐ Daily ☐ Weekly ☐ Monthly ☐ Every few months ☐ A few times a year

Section C: To be completed for testing and therapy clients

Living Situation

Residence: ☐House ☐Apartment ☐Dormitory ☐Fraternity/Sorority House ☐ Other, specify:

Location: ☐On-Campus ☐Off-Campus Length of Commute: _____ hours _____ minutes

Atmosphere in home: ☐Peaceful ☐Loving ☐Supportive ☐Cooperative ☐Frequent Conflict ☐Hostile ☐Tense

Comments:

Please list the names, ages, and gender of those who live in the home with the client:		
Name	**Relationship**	**Age**

Other people who are actively involved in the client's life:

Stressful Events & Family History			
☐ None Reported	☐ Family Violence	☐ Custody Issues	☐ Homelessness
☐ Legal Problems	☐ Sexual Abuse as Child	☐ Sexual Abuse as Adult	☐ Birth/Death (circle)
☐ Divorce	☐ Illness (mental/physical)	☐ Physical Abuse as Child	☐ Physical Abuse as Adult
☐ New/Beginning School	☐ Marriage	☐ Witnessed Violence	☐ Family Substance Abuse
☐ Separation from family/friends	☐ Multiple Family Moves/Recent Moves		☐ Other:

Section D: Please complete if reason for intake is psychological/educational testing

(If the purpose of intake is therapy only, skip to Section E)

Developmental/Medical History

Is the client adopted?	☐ Yes	☐ No
If so, at what age and from where?		
Was the child/client a planned pregnancy?	☐ Yes	☐ No
Was the client's mother under a doctor's care?	☐ Yes	☐ No
Number of client's mother's previous pregnancies/miscarriages?		

Check any of the following complications that occurred during the pregnancy of the client			
☐ Difficulty in Conception	☐ Toxemia	☐ Abnormal Weight Gain	☐ Flu
☐ Measles	☐ Excessive Vomiting	☐ German Measles	☐ High Blood Pressure
☐ Excessive Swelling	☐ Emotional Problems	☐ Vaginal Bleeding	☐ Anemia
☐ Other: List			

☐ Maternal Injury	Describe:				
☐ Hospitalization during Pregnancy	Reason:				
☐ X-Rays during Pregnancy	What month?				
☐ Medications used during Pregnancy	What kind?				
☐ Alcohol/Drugs used during Pregnancy	Type:		Frequency:		
☐ Cigarettes used during pregnancy	Frequency:				
At the client's birth, what was the mother's age?			Father's age?		
Mother's age at birth of first child?			Father's age?		
Was the client born in a hospital?	☐ Yes	☐ No			
Length of Pregnancy		Weeks		Birth Weight:	
Length of Labor		Hours		Apgar Score	
Client's Condition at Birth					
Mother's Condition at Birth					

Check any of the following complications that occurred during birth							
☐ Forceps Used	☐ Breech Birth		☐ Labor Induced		☐ Caesarean Delivery		
☐ Other Delivery Complications							
☐ Incubator: How long?							
☐ Jaundiced?							
☐ Breathing Problems?							
☐ Supplemental Oxygen?							
☐ Length of Stay in Hospital	Client's Mother:	Days	Client:	Days			
At what age did the client first do the following? Please indicate year/month of age							
Turn Over			Walk Down Stairs				
Sit Alone			Show interest in or Attraction to Sound				
Crawl			Understand First Words				
Stand Alone			Speak First Words				
Walk Alone			Speak in Sentences				
Walk up Stairs							
Was this child breast-fed?	☐ Yes ☐ No		When Weaned?				
Was this child bottle-fed?	☐ Yes ☐ No		When Weaned?				
When was this child toilet-trained?	**Days:**		**Nights:**				
Did bed-wetting occur after toilet training?	☐ Yes ☐ No		If yes, until what age?				
Did bed-soiling occur after toilet training?	☐ Yes ☐ No		If yes, until what age?				
Were there any medical reasons for bed-wetting or bed-soiling?	☐ Yes ☐ No	If yes, please describe below:					
Has the client experienced any of the following problems? If yes, please describe.							
Walking difficulty	☐ Yes ☐ No						
Unclear Speech	☐ Yes ☐ No						
Feeding Problem	☐ Yes ☐ No						
Underweight Problem	☐ Yes ☐ No						
Overweight Problem	☐ Yes ☐ No						
Colic	☐ Yes ☐ No						
Sleep Problem	☐ Yes ☐ No						
Eating Problem	☐ Yes ☐ No						
Difficulty Learning to Ride a Bike	☐ Yes ☐ No						
Difficulty Learning to Skip	☐ Yes ☐ No						
Difficulty Learning to Throw or Catch	☐ Yes ☐ No						
During the client's first 4 years, were any special problems noted in the following areas? If yes, please explain.							
Eating	☐ Yes ☐ No						
Motor Skills	☐ Yes ☐ No						
Sleeping Too Much	☐ Yes ☐ No						
Temper Tantrums	☐ Yes ☐ No						
Sleeping Too Little	☐ Yes ☐ No						
Failure to Thrive	☐ Yes ☐ No						
Separating from Parents	☐ Yes ☐ No						
Excessive Crying	☐ Yes ☐ No						
If endorsing any of the following medical conditions, include the year they occurred:							
☐ Measles	☐ Rheumatic Fever		☐ German Measles		☐ Diphtheria		
☐ Mumps	☐ Meningitis		☐ Chicken Pox		☐ Encephalitis		
☐ Tuberculosis	☐ Anemia		☐ Whooping Cough		☐ Fever Above 104^0		
☐ Scarlet Fever	☐ Sustained High Fever		☐ Head Injury: Describe				
☐ Coma or any loss of Consciousness: Describe							
☐ Broken Bones	**If yes, please list location of break:**						

Explain the medical conditions checked above:	

Has the client received developmental therapies (Speech, Occupational, Physical, & Developmental)?	☐ Yes ☐ No

If so, please complete the following:

Type of Therapy	Location of Therapy	Dates of Therapy	Length of Therapy

Section E: To be completed for testing and therapy clients

Please describe any serious illnesses or operations (and date of each) for the client:

Please indicate whether the client currently has any of the following problems. If yes, describe how often.

RESPIRATORY		
Frequent Colds	☐ Yes ☐ No	
Chronic Cough	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Hay Fever	☐ Yes ☐ No	
Sinus Condition	☐ Yes ☐ No	
CARDIOVASCULAR		
Shortness of Breath or Dizziness with Physical Exertion	☐ Yes ☐ No	
Activity Limitation Due to Heart Condition	☐ Yes ☐ No	
Heart Murmur	☐ Yes ☐ No	
GASTROINTESTINAL		
Excessive Vomiting	☐ Yes ☐ No	
Frequent Diarrhea	☐ Yes ☐ No	
Constipation	☐ Yes ☐ No	
Stomach Pain	☐ Yes ☐ No	
GENITOURINARY		
Urination in Pants/Bed	☐ Yes ☐ No	
Pain While Urinating	☐ Yes ☐ No	
Excessive Urination	☐ Yes ☐ No	
Strong Odor to Urine	☐ Yes ☐ No	
MUSCULOSKELETAL		
Muscle Pain	☐ Yes ☐ No	
Clumsy Walk	☐ Yes ☐ No	
Poor Posture	☐ Yes ☐ No	
Other Muscle Problems	☐ Yes ☐ No	

SKIN		
Frequent Rashes	☐ Yes ☐ No	
Bruises Easily	☐ Yes ☐ No	
Sores	☐ Yes ☐ No	
Severe Acne	☐ Yes ☐ No	
Itchy Skin (Eczema)	☐ Yes ☐ No	
NEUROLOGICAL		
Seizures/Convulsions	☐ Yes ☐ No	
Speech Defects	☐ Yes ☐ No	
Accident Prone	☐ Yes ☐ No	
Bites Nails	☐ Yes ☐ No	
Sucks Thumb	☐ Yes ☐ No	
Grinds Teeth	☐ Yes ☐ No	
Has Tics/Twitches	☐ Yes ☐ No	
Bangs Head	☐ Yes ☐ No	
Rocks back and forth	☐ Yes ☐ No	
Bowel Movements in Pants/Bed	☐ Yes ☐ No	
ALLERGIES		
Allergy to Medicine	☐ Yes ☐ No	
Allergy to Food	☐ Yes ☐ No	
Other Allergies	☐ Yes ☐ No	
SPEECH		
Stuttering	☐ Yes ☐ No	
Unclear Speech	☐ Yes ☐ No	
Other Speech Problems	☐ Yes ☐ No	
HEARING		
Ear Infections	☐ Yes ☐ No	
Hearing Problems	☐ Yes ☐ No	
Ear Tubes	☐ Yes ☐ No	
Date of Most Recent Hearing Exam		
VISION		
Vision Problems	☐ Yes ☐ No	
Wears Glasses or Contacts	☐ Yes ☐ No	
Date of Most Recent Vision Exam		

What is the client's overall physical health?

- ☐ Usually good health/physically fit
- ☐ Has a health condition that does not require medication:
- ☐ Has a health condition that requires medication:

Does the client take any medications for a medical condition on a regular basis? ☐ Yes ☐ No

If yes, please specify medication and purpose:

Name	Purpose	Dosage	Prescribing doctor

Has the client ever been diagnosed with a psychological disorder?			☐ Yes ☐ No
If yes, please specify when and by whom:			
Name of Disorder	**Name of Clinician/Clinic**	**Date of Diagnosis**	**Is it current?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Has the client ever been hospitalized for a psychological issue?			☐ Yes ☐ No
If yes, please specify when, where, and for what reason:			
Name of Hospital	**Date of Hospitalization**	**Reason for Hospitalization**	
Has the client ever seen a therapist (Psychiatrist, Psychologist, Counselor, Social Worker)?			☐ Yes ☐ No
If yes, when and reason for treatment?			
Name of Clinic	**Dates of Services**	**Reason for Therapy**	**Name of Therapist**
If yes, was it helpful?			☐ Yes ☐ No
Is there a family history of any DIAGNOSED mental health issues?			☐ Yes ☐ No
If yes, check the disorder and list the relative(s) diagnosed with it:			

		Relatives			**Relatives**
☐	ADHD		☐	Autism/Asperger's	
☐	Alcohol Abuse		☐	Learning Disability	
☐	Substance Abuse		☐	Anxiety	
☐	Bipolar		☐	Mental Retardation	
☐	Depression		☐	Schizophrenia	
☐	PTSD		☐	Conduct Disorder	
☐	Borderline Personality Disorder		☐	Alzheimer's	
☐	Other:				

Section F: To be completed for testing and therapy clients

Substance Abuse History

☐ Client has no history of substance use or abuse

Substance	First Usage (Month/Year and/or Age)	Last Usage (Month/Year and/or Age)	Frequency	Quantity	Treatment
Alcohol					
Amphetamines					
Cigarettes/Tobacco/Vape					
Cocaine					
Hallucinogens					
Inhalants					
Marijuana					
Opiates					
PCP					
Prescription Drugs					
Other:					

Comments:

How much sleep does the client typically get each night? (If the client regularly naps, add to total)

	Less than 6 hours		6-7 hours		7-8 hours
	8-9 hours		9-10 hours		More than 10 hours
	No typical amount of sleep		Not sure		

How soundly does the client sleep?

	Sleeps so soundly that the client cannot be awakened easily
	Usually sleeps soundly
	Usually awakens at least once during the night
	Doesn't seem to be able to sleep soundly
	Stays up much of the night playing video games or online

If the client does nap, how long is a 'typical' nap?

Have you noticed any recent changes in appetite or weight in the client? ☐ Yes ☐ No

If yes, please explain:

Any activities of daily living limitations? ☐ Yes ☐ No

If yes, please explain:

If one thing could change about the client, what would it be?

Section G: To be completed for testing and therapy clients

Social, Temperament & Abuse History

How would you rate the client's current social support?

	Has a strong social support network
	Has a few people in the family on which the client can count
	The client's support comes from people outside the family
	The client has almost no social support
	The client has no support at all

Explain:

Describe the client's legal system involvement:

	The client is currently involved in the legal system and this treatment is court-ordered
	The client is currently involved in the legal system, but treatment is voluntary
	The client has a past history of legal involvement (Explain):
	The client has no legal system involvement

Current Resources (Check all that apply)

	Clubs		Intramural Sports		Fraternity/Sorority
	Church		Sports		ROTC/Military
	Public Assistance				

Social/Peer Relations (Check all that apply)

	Normal		Interactive		Cooperative
	Isolative		Aggressive		Controlling
	Other:				

Choose the words that best describe the client's temperament (personality): (Check all that apply)

	Accommodating		Emotional		Obedient
	Active		Happy		Outgoing
	Affectionate		Hyperactive		Reserved
	Argumentative		Impatient		Shy
	Calm		Impulsive		Sociable
	Caring		Independent		Stubborn
	Conscientious		Intelligent		Trusting
	Demanding		Insecure		Unhappy
	Determined		Irritable		Difficult
	Motivated		Creative		Bossy

Check any of the following the client has experienced:

	Verbal Abuse	By whom?	
	Physical Abuse	By whom?	
	Sexual Harassment	By whom?	
	Sexual Abuse	By whom?	
	Rape	By whom?	
	Sex Trafficking	By whom?	

If client has experienced any abuse, was it reported? Outcome of report?

Section H: To be completed for testing and therapy clients (More relevant if being evaluated for learning/ADHD/Autism)

School/Educational Information

NAMES	GRADES/YEARS	LOCATION

What are/were considered to be the client's strongest academic areas?

In what academic areas does client needs help?

At what age of the client did you first begin to notice a need for help in the areas listed above?

Has anyone else expressed concern regarding the client's academic performance?	☐ Yes	☐ No
If yes, please elaborate:		

Has the client ever repeated a grade?	☐ Yes	☐ No

If yes, please specify the grade and the reason for it:							
Describe the client's grades (or attach copies of grade reports):							
Are the client's grades better on:		☐	**Tests**	☐	**Independent Classwork**		
		☐	**Homework**	☐	**Group Classwork**		
Does the client have behavioral or social problems in school?						☐ Yes	☐ No
If yes, please describe:							
Is the client receiving special education services?						☐ Yes	☐ No
If yes, under which category:							
☐	Learning Disability	☐	Intellectual Disability	☐	Other Health Impaired	☐	Speech/Language
☐	Physical Impairment	☐	Hearing Impairment	☐	Emotional Disturbance	☐	Autism
☐	Visual Impairment	☐	Deaf/Blindness	☐	Multiple Disabilities	☐	Traumatic Brain Injury
Explain the reason for the impairment:							
Does the client have a 504 Plan (or behavior plan)?						☐ Yes	☐ No
Explain:							

ADDITIONAL INFORMATION

Form Completed by:
☐ Self (Client) ☐ Spouse/Significant ☐ Other Parent/Guardian ☐ Friend
If other than the client or parent/guardian, please include your name:
For administrative assistance (to change an appointment time, etc…), please contact 501-932-0255. If you would like to fax information to us, our fax number is 501-932-0258. If you have any questions pertaining to therapy or a testing procedure or the scope of this form, please contact us. You can also email us at c-pac@conwaypsychtesting.com

AGREEMENT TO CARE
You are requesting an evaluation and/or therapy from a Conway Psychological Assessment Center. You understand that testing and/or therapy at CPAC is voluntary and that you may discontinue treatment at any time.

CONFIDENTIALITY
All information between you and the provider is strictly confidential unless you specifically authorize release in writing or in compliance with certain legal requirements. The purpose of an evaluation is to compile as much information about the client as possible in order to provide a differential diagnosis. Therefore, the information collected will be included in the report unless specifically stated. CPAC is required to inform others to take protective measures if a client presents a physical danger to self or others, or if client or elder abuse is suspected. Please discuss any concerns with the client's therapist or doctor.

MISSED APPOINTMENTS
CPAC makes every effort to give an appointment in a timely manner. When you fail to make your scheduled appointment time and we are not notified, we are unable to schedule someone else in your place. This makes it more difficult for us to see all clients requesting appointments, raises the cost of doing business, and impacts the insurance rates you are charged. We are unable to bill your insurance carrier for missed appointments. **You are personally responsible for a $50 fee for missed appointments.**

TO AVOID BEING CHARGED FOR THE FULL COST OF MISSED APPOINTMENTS, PLEASE CANCEL APPOINTMENTS AT LEAST 24 HOURS IN ADVANCE.

RELEASE OF INFORMATION
I authorize the release of information regarding my care or the care of my child, including release of my mental health records, to my health plan or insurance company for the payment of claims, certifications/case management decisions, quality improvement activities, and other purposes related to the administration of benefits for my health plan or insurance coverage.

RESPONSIBILITY FOR PAYMENT
I agree to pay any fees I incur for services rendered by Conway Psychological Assessment Center for my client, regardless of insurance coverage.

I UNDERSTAND THAT ALL FEES AND COPAYMENTS ARE DUE AND PAYABLE AT THE TIME OF MY VISIT.

WE ACCEPT CASH, VISA, MASTERCARD OR DISCOVER FOR PAYMENT. WE ARE UNABLE TO ACCEPT CHECKS OR AMERICAN EXPRESS.

Client/Parent/Guardian's Signature **Date**

Relationship of Signer

Authorization/Consent for Release of Medical/Educational Information

I, _____ [Insert Name of Patient/Client] whose Date of Birth is _____, authorizes Conway Psychological Assessment Center (CPAC) to disclose to and/or obtain from:

_____the following information:
[Insert Name of Person or Title of Person or Organization]

Purpose of the Disclosure: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed)

_____	Psychological Evaluations	_____	Educational History (Grades, Discipline Records)
_____	Diagnosis	_____	TRIAND Records (Standardized test results/Benchmarks)
_____	Psychotherapy Notes	_____	Psychoeducational Evaluations
_____	Treatment Plan or Summary	_____	Speech/OT/PT/Developmental Assessments
_____	Current Treatment Update	_____	Special Education Records
_____	Psychiatric Evaluation	_____	IEP/504 Plan
_____	Medication Management Information	_____	Learning Intervention Records
_____	Discharge/Transfer Summary	_____	Other _____

I also authorize release of information regarding (Initial if giving consent):

_____ Alcohol and/or Substance Abuse History _____ HIV/AIDS or other communicable disease

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR ABUSE SUBSTANCE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal Rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Dates of treatment (if known): _____

Revocation/Expiration:

I understand that a photocopy of this release will give the same authorization as the original. I understand that once disclosed the information will no longer be private and may no longer be protected by federal privacy laws and regulations**. I understand by affixing my name that C-PAC may have VERBAL CONTACT with the above named organization/person.** I understand that I may revoke this consent in *writing* at any time, but such revocation shall have no effect on disclosures previously made. Unless I revoke this authorization prior to its expiration, the authorization to release information will automatically expire 90 (ninety) days after the patient's completion of treatment or: ☐ 90 days from the date of my signature ☐ OR it will ***expire*** on this date_____. I need not sign in order to assure treatment. I, the undersigned, understand I am releasing the above information for the stated purpose of my own free will. I attest that this consent was **totally completed** prior to affixing my signature.

_____ _____ _____
Signature of Client or Parent/Guardian Date Relationship to Client

_____ _____
Witness (1) Witness (2) If requested

If verbal consent print name of Parent/Guardian who gave consent: _____