Neslihan G. Chandler, PhD
Licensed Clinical Psychologist

3815 Lisbon Street, Suite 202 Fort Worth, TX 76107
(817)350-6774 fax- (817)769-2352
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Hello!

I look forward to working with you. Enclosed are directions to my office as well as an application and policies. Here is a checklist of the forms that need to be completed:

___ Application for services

___ Credit Card Information to Secure Your Appointment

Once all forms are completed and signed, **please email/fax them to Dr. Chandler before your 1st appointment.** If you do not know some of the information on the application, don't worry! We will discuss each item during your first appointment.

Please make sure your have provided your Credit Card info to secure your appointment. The credit card provided will be used for cancelation purposes and all charges unless. You will be given the opportunity to use other methods of payment at the time of service if you wish, but you must let Dr. Chandler know prior to the end of your appointment. Please see the Payment Policy Form & Cancellation fee below for pricing of each appointment.

If you have any questions about the forms or have questions in general please do not hesitate to contact me at the above email. I will do my best to get back to you as soon as possible!

Thank you,

Neslihan Chandler, PhD

Directions:
From I-30 exit Montgomery St, and turn south (left if you are coming from Dallas, right if you are coming from west). Turn right onto first street, Locke Ave. Take 1st left onto Landers St. Our building will be on corner of Landers & Lisbon street and it is a red brick building. **Please dial *2020 on intercom at door to be buzzed into building.**

From Vickery- Take Vickery Blvd. heading towards downtown, take left on Landers St (street right before Montgomery). Cross over Vickery Westbound. Our building will be on corner of Landers & Lisbon street and it is a red brick building. Please use intercom at door to enter building. **Please dial *2020 at intercom at door to be buzzed into building.**

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APPLICATION FOR SERVICES

Personal Information

Name_____ Prefer to be Called _____

Date of Birth_____Age_____Gender _____Marital Status _____

Preferred Pronouns (he/him, she/her, they/them) _____

Address_____

City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Email _____

Your Highest Degree attained_____

Current Job Title _____

Family History

Mother's Name & Occupation_____

Highest Degree attained_____

Mother's side has a history of (please check all boxes that apply):

- ☐ ADHD
- ☐ Learning Problems
- ☐ Dyslexia
- ☐ Depression
- ☐ Anxiety
- ☐ Obsessive Compulsive
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Autism
- ☐ Eating Disorders
- ☐ Genetic Syndromes
- ☐ Personality Disorders
- ☐ Intellectual Disability

Father's Name & Occupation_____

Father's Highest Degree attained_____

Father's side has a history of (please check all boxes that apply):

- ☐ ADHD
- ☐ Speech Problems
- ☐ Learning Problems
- ☐ Dyslexia
- ☐ Depression
- ☐ Anxiety
- ☐ Intellectual Disability
- ☐ Obsessive Compulsive
- ☐ Bipolar Disorder
- ☐ Autism
- ☐ Psychiatric Disorders
- ☐ Genetic Syndromes
- ☐ Slow Learning

Parent Address_____

Parent Phone Number_____

Parent Email _____

Emergency Contact (nearest relative not living with you):

Name _____ Relationship _____

Phone # _____

<u>Household Members:</u>

Name _____ Age _____ Relationship_____

Name _____ Age _____ Relationship_____

Name _____ Age _____ Relationship_____

Name _____ Age _____ Relationship_____

Name _____ Age _____ Relationship_____

Referral Information

Referred by _____

Phone number_____

What concerns prompted need for testing?

_____

_____

_____

Psychological History

Do you have a psychiatric diagnosis? If so, what?_____

Do you take any medications regularly? If so, what?_____

Have you had any previous psychological testing? If so, when and where? What were the results? _____

_____

Have you ever received, or is still currently receiving, the following services?

- ☐ Medication Management (if so what medication_____)
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ 504 Modifications
- ☐ ABA
- ☐ Counseling

Do you have any current or past stressors within the last 6 months? (check all that apply)

- ☐ Parent Separation or Divorce
- ☐ Moves to different schools
- ☐ Loss/Death of family member
- ☐ Loss/Death of friend or pet
- ☐ Moves to different homes
- ☐ Social problems

Pregnancy and Birth History

Were you adopted?_____ If so, at what age? _____

Length of pregnancy _____ weeks (if known) Birth weight_____lbs _____ oz

Mother's age at time of pregnancy _____ Father's age at time of pregnancy_____

Problems with pregnancy? (check all that apply):

- ☐ Bleeding/spotting
- ☐ Gestational Diabetes
- ☐ High Blood Pressure
- ☐ Alcohol Used
- ☐ Tobacco Used
- ☐ Infections
- ☐ Prescribed Medications (if yes, please list _____)
- ☐ Other drugs used (if yes, please list _____)

Delivery was:

- ☐ Vaginal
- ☐ Caesarean
- ☐ Forceps used
- ☐ Vacuum assisted

If Caesarean, why?_____

Problems in nursery? (check all that apply)

- ☐ Problems breathing
- ☐ Feeding Problems
- ☐ Jaundice
- ☐ Heart Problems
- ☐ Feeding Problems
- ☐ Infections
- ☐ High/Low Blood Sugar
- ☐ Seizure

Health and Medical History

Are you seeing a specialist of any kind? (neurologist, physiatrist, or counselor) If so, please list why and name of specialist _____

_____

Have you ever been hospitalized? If yes, please describe _____

Have you had any surgeries? If yes, please describe _____

Are there any other medical problems?_____

Do you have any sleep problems? If yes, please describe_____

_____

Do you have any eating problems? If yes, please describe _____

_____

Have you had any of the following? (please check all that apply)

- ☐ Ear infections
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Seizures
- ☐ Motor/vocal tics
- ☐ Headaches
- ☐ Texture issues with food
- ☐ Sensory problems

Developmental History

Did you have or had any delays in the following areas? If so, please explain

Communication: _____

Large Motor Skills: _____

Fine Motor Skills: _____

Social History

Is it difficult for you to make friends?	☐ Yes	☐ No
Do you have a best friend or significant other?	☐ Yes	☐ No
Is it difficult to socialize with others compared to your peers?	☐ Yes	☐ No

Behavior Checklist

Please check how often you have experienced following behaviors in the last 6 weeks:

	Not at all	Just a little	Often
Has difficulty staying focused on tasks			
Is easily distracted			
Makes careless mistakes			
Loses things			
Is forgetful			
Has difficulty sitting still			
Is "on the go"			
Makes poor eye contact			
Worries			
Feels irritable			
Difficulty falling or staying asleep			
Seems sad or depressed			
Has made suicidal statements			
Has hurt him/herself			

School Information

Are you currently in school? If so, what school and degree program are you in?

_____

Did you ever have to repeat a grade in school?_____

If you are in school, are you failing any subjects?_____

Do you receive modifications in any way?_____

Please check any areas that you are struggling in:

- ☐ Reading
- ☐ Reading Comprehension
- ☐ Spelling
- ☐ Math Skills
- ☐ Written Expression
- ☐ Speech/Language Difficulties
- ☐ Attention/Focus Issues

Is there anything else that you would like to share that was not asked on the application?

_____

_____

_____

_____

_____

Signature

_____

Printed Name

_____

Date

PRIVACY PRACTICES STATEMENT

Please sign and submit with your application

I have read, or have had read to me, the issues and points regarding privacy. By my signature below, I acknowledge that I have received a copy of the Notice of Privacy Practices. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I hereby agree to the privacy notice and to cooperate fully and to the best of my ability.

_____

Signature Date

_____

Name

After you have signed this consent, you have the right to revoke it by writing a letter telling me you no longer consent. I will comply with your request about using or sharing your personal information from that time on, but I may have already used/shared some of your information and cannot retrieve what has already been shared. Please read this carefully before you sign this Consent form. If you do not sign this consent form agreeing to our privacy practices, we cannot complete an evaluation for you or your child or provide any psychological services to you.

CONSENT FOR TREMTMENT & PAYMENT POLICY

By signing below, I consent to be evaluated by Dr. Neslihan Chandler. I attest that I am legally able to make medical decisions for myself.

I also agree to the fees outlined below and agree to pay for each service at the conclusion of each appointment. I also agree that if I need to cancel any appointment that I do so within 48 hours to avoid paying a no-show fee of 50% of the fee for the appointment.

Diagnostic Interview - $300
Psychological Testing -$1800
Feedback Session- $300

The fee for each session will be due and must be paid at the conclusion of each session. Check, cash, or credit cards are acceptable methods of payment. Once an appointment is scheduled, that time is reserved only for you. If you are unable to attend your appointment, please contact Dr. Chandler at least **48-hours** in advance so that she may be able to fill that appointment with a client from her waiting list. If Dr. Chandler does not receive 48 hours advance notice (except in the case of illness, inclement weather, or death in the family), you will be responsible for 50% of the fee for your appointment. A credit card will be required to confirm and secure your appointment. At the time of services, you can request another card be used for pay for services if you like. By signing below, you also authorize Dr. Chandler to charge your credit card provided (to secure your appointment) for cancelation fees, past due invoices, or any other outstanding charges.

If you wish to seek reimbursement for services from your health insurance company or medical savings account (flexible spending account), Dr. Chandler can provide a receipt for you to submit to your insurance company at your last appointment. Most insurance companies require a diagnosis to reimburse for services. If there are any concerns about sharing your diagnosis you may speak to Dr. Chandler about this before you decide to send the receipt to the insurance company.

Signature Date

Patient Name

CONSENT FOR DISCLOSURE OF INFORMATION

Please sign and submit with your application

I consent Dr. Chandler and the person/institution below to release/share information for the purpose of coordinating my care. This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent, but also understand that information, once released, cannot be retrieved.

Name Address/Phone

_____ _____

_____ _____

_____ _____

_____

Signature

_____

Patient Name Date

NOTICE OF PRIVACY PRACTICES

This is for you to keep for your records

The Health Insurance Portability & Accountability Act of 1998 (also known as "HIPPA") is a federal mandate that requires all medical records and other protected health information used or disclosed by a provider in any form (i.e., electronically, orally, or via paper) be kept properly confidential. HIPPA gives the patient rights on how to understand and control how their health information is used. HIPPA also can penalize entities or persons who do not act within accordance of this act.

As required by HIPPA, below is an explanation of how I am to maintain your privacy of your confidential health information. Additionally, how your information can be disclosed and used is also detailed.

Dr. Chandler may use and disclose your records for treatment and payment purposes only. Treatment entails providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include providing a copy of your report to your child's pediatrician or school.

Payment entails sending information to obtain reimbursement for services, billing or collection services, and utilization review. An example of this would be sending an unpaid invoice to a collections agency if the invoice 60 days overdue.

Dr. Chandler may contact you for appointment reminders or about treatment recommendations or other related services that may benefit you or your child. By signing the privacy practice agreement, you agree to receive text messages and/or emails through Dr. Chandler's HIPPA compliant phone line and/or email service. Any other uses or disclosures must be made by written authorization. Also, your information will never be shared with third party advertisers. You may revoke your authorization in writing at any time however if information has already been shared based on written authorization given by you, that information cannot be retrieved.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place for more privacy. For example, you could ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can request that I limit what is disclosed to any people who are involved in your treatment or the payment for treatment, such as family members or friends. If I agree to the request, I would attempt to keep that agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at your health information, such as billing records or health records, such as a psychological report. You will receive a copy of your report and receipt at the 3rd and final appointment (i.e., the feedback appointment). However, if you need additional paperwork (i.e., a

letter, a modified report, etc.) these can be provided at an additional fee.

4. If you believe that any information in your records is incorrect or missing important information, you can ask to have some kinds of changes (termed "amending") to your health information. You would have to make such a request in writing and send it to the office, and you would also need to write the reasons that you want to make the changes.
5. You have the right to have a copy of this notice. If I make any changes to either form, I will post the new version on my website, and you could always get a copy of the new NPP from me.
6. You have the right to file a complaint if you believe that your privacy rights have been violated. You can file such a complaint with me personally and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint regarding privacy will not in itself change the health care that you receive at this office.

In all but a few rare situations, your privacy is protected by state law and by the rules of our profession. Here are the most common situations in which confidentiality is *not* protected:

1. If you are sent to us by a court, the court expects a report. If this is your situation, please talk with me before you tell me anything you do not want the court to know. You have a right to tell me only what you are comfortable with telling. Court ordered evaluations belong to the court and the judge may not allow you to review them.
2. We are legally and ethically bound to respond to certain court requests. For example, courts routinely request psychological evaluations in divorce and custody proceedings or request your psychological records. Consult your lawyer for further details.
3. When examiners suspect that clients are a possible danger to themself and/or others, we are required to report that situation to the appropriate authorities.
4. Examiners are legally required to reported suspected child abuse, elder abuse, and abuse of a person who is disabled.

Except for the situations described above, Dr. Chandler will maintain your privacy. We also ask you not to disclose the name or identity of anyone you know who has been seen by us to anyone else.

Records are securely stored for ten years. If illness, disability, or other presently unforeseen circumstances arise, we ask that you to agree to transferring your records to another psychologist who will assure their confidentiality, preservation, and appropriate access.

Finally, please note that the Health Insurance Portability and Accountability Act of 1996 requires that you be provided with a Notice of Privacy Practices specifically outlining these privacy practices. A copy of that Notice is attached hereto. To the extent of any discrepancy between the foregoing and the Notice, the terms of the Notice shall apply.