

Neslihan G. Chandler, PhD

Licensed Clinical Psychologist

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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

___ Informed consent form

___ Hipaa Privacy Practices Form

Once all forms are completed and signed, please bring them to your first appointment. If you do not know some of the information on the application, don't worry about it! We will discuss each item during your first appointment.

Please make sure you have completed the Jot Form Credit Card link that was sent to you to confirm and secure your appointment. Your credit card provided will be used for cancelation purposes and past due invoices only. You will be given the opportunity to use other methods of payment at the time of service if you wish. 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 _____ Date of Birth _____

Age _____ Gender _____ Marital Status _____

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):

- | | |
|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Obsessive Compulsive |
| <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Genetic Syndromes |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Slow Learning |
| <input type="checkbox"/> Intellectual Disability | |

Father's Name & Occupation _____

Father's Highest Degree attained _____

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

- | | |
|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Obsessive Compulsive |
| <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Genetic Syndromes |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Slow Learning |
| <input type="checkbox"/> Intellectual Disability | |

Parent Address _____

Parent Phone Number _____

Parent Email _____

Emergency Contact (nearest relative not living with you):

Name _____ Relationship _____

Phone # _____

Household Members:

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?

- | | |
|---|--|
| <input type="checkbox"/> Medication Management (if so
what medication _____) | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> 504 Modifications |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> ABA |
| | <input type="checkbox"/> Counseling |

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

- | | |
|---|--|
| <input type="checkbox"/> Parent Separation or Divorce | <input type="checkbox"/> Loss/Death of friend or pet |
| <input type="checkbox"/> Moves to different schools | <input type="checkbox"/> Moves to different homes |
| <input type="checkbox"/> Loss/Death of family member | <input type="checkbox"/> 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):

- | | |
|---|---|
| <input type="checkbox"/> Bleeding/spotting | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Prescribed Medications (if yes, please list _____) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other drugs used (if yes, please list _____) |
| <input type="checkbox"/> Alcohol Used | |
| <input type="checkbox"/> Tobacco Used | |

Delivery was:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Vaginal | <input type="checkbox"/> Forceps used |
| <input type="checkbox"/> Caesarean | <input type="checkbox"/> Vacuum assisted |

If Caesarean, why? _____

Problems in nursery? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Problems breathing | <input type="checkbox"/> Feeding Problems |
| <input type="checkbox"/> Feeding Problems | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> High/Low Blood Sugar |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> 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)

- | | |
|---|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Motor/vocal tics |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Texture issues with food |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> 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:

- | | |
|---|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Reading Comprehension |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Math Skills |
| <input type="checkbox"/> Written Expression | <input type="checkbox"/> Speech/Language Difficulties |
| <input type="checkbox"/> Attention/Focus Issues | |

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

Signature

Printed 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 of more health care providers. An example of this would include providing a copy of your report to your doctor or school.

Payment entails sending information to obtain reimbursement for services, confirming coverage of insurance, billing or collection services, and utilization review. An example of this would be sending a bill for your visit to your insurance company.

Dr. Chandler may contact you for appointment reminders or about treatment recommendations or other related services that may benefit you and your child. Any other uses or disclosures must be made by written authorization. You may revoke your authorization in writing as any time however if information has already be 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 can even get a copy of these, provided that you reimburse for time and copy expenses involved.
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 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 or your employer 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 self and/or others, we are required to report that situation to the appropriate authorities.
4. Examiners are legally required to report suspected child, elder and disabled abuse.

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 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.

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 TREATMENT & 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 - \$275

Psychological Testing -\$1700

Feedback Session- \$275

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 cancellation 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