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 and your child. Enclosed are directions to my office as well as an application and policies. Here is a checklist of all that needs to be completed:

___ Application for services (Below)

_____Consent Forms and Privacy Policy

___ Credit Card Information to Secure your Appointment (given via phone to my assistant prior to your appointment)

Once all forms are completed and signed, please **email or fax them to me prior to your first** appointment. If you do not know some of the information on the application, that's ok! We will discuss each item during your first appointment.

Your credit card provided will be used **for all billing, 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, but you must let Dr. Chandler know if you would like to change your payment info **prior to the end of the appointment**. Please see the Payment Policy Form & Cancellation fee 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 follow instructions at the intercom at the front door to be buzzed into the 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 follow instructions at the intercom at the front door to be buzzed into the building.**

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APPLICATION FOR SERVICES

Child and Family Information

Child Name_____ Prefers to be Called_____

Date of Birth_____Child Age_____Child Gender _____

Child's Preferred Pronouns_____(he/him, she/her, they/them, etc.)

Parents/Guardians Names:

Mother/Parent 1 Name_____ Marital Status_____

Address_____

City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Email _____

Mother's/Parent 1 Occupation_____

Mother's/Parent 1 Highest Degree attained_____

Mother's/Parent 1 side has a history of (please check all boxes that apply):

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

Father/Parent 2 Name_____ Marital Status_____

Address_____

City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Email _____

Father's/Parent 2 Occupation_____

Father's/Parent 2 Highest Degree attained_____

Father's/Parent 2 side has a history of (please check all boxes that apply):

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

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

Child Referred by _____

Phone number_____

What concerns prompted need for testing?

_____

_____

_____

What age did your child first start having these problems? _____

Child Psychological History

Does your child have a psychiatric diagnosis? If so, what?_____

Does your child take any medications regularly? If so, what?_____

Has your child had any previous psychological testing? If so, when and where? What were the results? _____

_____

Has your child ever received, or is still currently receiving, the following services?

- ☐ ECI
- ☐ PPCD
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ 504 Modifications
- ☐ ABA
- ☐ Counseling

Does your child have any current or past stressors? (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 or Bullying

Pregnancy and Birth History

Was this child adopted?_____ If so, at what age? _____

Length of pregnancy _____ weeks Birth weight_____lbs _____ oz

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

Prenatal care began at _____ trimester (1st, 2nd, or 3rd)

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 _____)

How long was the labor? _____ hours

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
- ☐ Seizures

Health and Medical History

Is your child seeing a specialist of any kind? (neurologist, physiatrist, or counselor) If so, please list why and give name _____

_____

Has your child been hospitalized? If yes, please describe _____

Has your child had any surgeries? If yes, please describe _____

Are there any other medical problems?_____

Does your child have any sleep problems? If yes, please describe_____

_____

Does your child have any eating problems? If yes, please describe _____

_____

Has your child 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

Has your child had any delays in the following areas? If so, please explain

Communication: _____

Large Motor Skills: _____

Fine Motor Skills: _____

Toileting skills: _____

Do you feel like your child functions at his or her own age level? Yes _____ No _____

If not, at what age level does he or she seem to function at? Like a_____year old

Social History

Are your concerned about your child's ability to make friends? ☐ Yes ☐ No

Does your child have a best friend? ☐ Yes ☐ No

Does your child show interest in other children? ☐ Yes ☐ No

Behavior Checklist

Please check how often your child has done the following behaviors in the **last 6 months**:

	Not at all	Just a little	Often
Has difficulty staying focused on tasks			
Is easily distracted			
Has difficulty sitting still			
Is "on the go"			
Makes poor eye contact			
Has trouble with language use			
Has trouble interacting with other children			
Acts as if he/she is in his/her own world			
Has repetitive or restrictive behaviors			
Is destructive of property			
Hurts himself			
Does not follow rules or directions			
Seems sad or depressed			
Has made suicidal statements			
Has hurt him/herself			

School Information

School:_____ School District_____

Grade _____ Has your child ever repeated a grade?_____

Is your child failing any subjects? If so, which ones?_____

Does your child receive modifications in any way?_____

Please check any areas that your child is struggling in:

- ☐ Reading
- ☐ Phonics/Learning sounds
- ☐ Spelling
- ☐ Written Expression
- ☐ Handwriting
- ☐ Reading Comprehension
- ☐ Math Skills
- ☐ Math Reasoning (word problems)
- ☐ Copying from the Board
- ☐ Speech/Language Difficulties

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

_____

_____

_____

_____

_____

Parent Signature

_____

Relationship to Child

_____

Date

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child D was on medication D was not on medication D not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1 - 9: _____

Total number of questions scored 2 or 3 in questions 10 - 18: _____

Total Symptom Score for questions 1 - 18: _____

Total number of questions scored 2 or 3 in questions 19 - 26: _____

Total number of questions scored 2 or 3 in questions 27 - 40: _____

Total number of questions scored 2 or 3 in questions 41 - 47: _____

Total number of questions scored 4 or 5 in questions 48 - 55: _____

Average Performance Score: _____

NICHQ

National Initiative for Children's Healthcare Quality

McNeil

Consumer & Specialty Pharmaceuticals

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.

_____

Child's name Date

_____ _____

Parent/Legal Guardian Relationship to patient

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 have my child evaluated by Dr. Neslihan Chandler. I attest that I am legally able to make medical decisions for my child. I 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 -$650-1800 (this exact amount was given to you by Dr. Chandler or her assistant)
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 to pay using another credit card if you prefer. However, **you must let Dr. Chandler know before the end of your appointment if you wish to use another form of payment**. By signing below, you authorize Dr. Chandler to charge your credit card for services rendered, cancelation fees, past due invoices, or any other outstanding charges.

If you wish to seek reimbursement for my services from your health insurance company or medical savings account (flexible spending account), you may use the receipt that I provide to all clients after the last appointment. Most insurance companies require that I provide a diagnosis for your child to reimburse for my services, so if you have any concerns about this you can discuss them with me at the last appointment.

_____

Child Name Date of Birth

_____

Parent Signature Date

_____

Parent Printed Name

CONSENT FOR DISCLOSURE OF INFORMATION

Please sign and submit with your application

I give my permission for Dr. Neslihan Chandler, PhD to share and/or obtain information with/from the persons/s listed below. This consent includes sharing the final psychological report, obtaining/sharing documents needed, or obtaining/sharing information that would be helpful for coordinating care.

Name	Email/Fax/Phone
_____	_____
_____	_____
_____	_____

I consent for information to be released/shared for the purpose of coordinating my care with Dr. Chandler and for reasons stated above in the Privacy Statement. 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.

Child Name	Date of Birth
Parent Signature	Date
Parent Printed Name	

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.