PEDIATRIC PSYCHOLOGY ASSOCIATES

Aventura • Weston • Coral Gables
Miami-Dade (305) 936-1002
Broward (954) 753-1112
Fax (305) 936-1022

CHILD INTAKE/HISTORY FORM

Child's Name_____ Date_____

Age_____ Birthdate_____ Birthplace_____

Grade_____ School_____

Home Street Address_____

City_____ State_____ Zip Code_____

Home Ph#_____ Child's Cellular (if applicable)_____

What are the concerns or difficulties that cause you to seek professional help at this time?

_____

_____

_____

FAMILY INFORMATION

Mother's Name_____Age_____ Birthdate_____

Occupation:_____ Education_____

Cellular_____Email:_____

Home/Business/Alternate Phone Number_____

Age at time of Marriage_____ Age at time of Divorce (if applicable)_____

Father's Name_____Age_____ Birthdate_____

Occupation:_____ Education_____

Cellular_____Email:_____

Home/Business/Alternate Phone Number_____

Age at time of Marriage_____ Age at time of Divorce (if applicable)_____

Is child living with biological or adoptive parents (circle one)?

Is child living with both parents? Yes _____ No _____

If parents are living apart (separated or divorced) is the other parent aware that you are seeking psychological services for your child?* Yes _____ No _____

*A consent from must be signed by the other parent if parents are divorced or living apart.

Please list other parent's information below:

Name and Best Contact Number_____

Street Address_____

City_____State_____ Zip Code_____

If child is not living with both biological/adoptive parents, describe living/visitation arrangements:

_____

_____

Siblings

Name Gender Age School/Occupation

_____

_____

_____

Other Persons in the Home

Name Age Relation

_____

_____

How does your child get along with:

Mother?_____Father?_____

Sister(s)?_____ Brother(s)?_____

If applicable, relationship with parent's significant other or step-parent?_____

DEVELOPMENTAL AND HEALTH INFORMATION

Pediatrician's name_____ Telephone number:_____

Date of last medical checkup?_____ Height_____ Weight_____

What is your child's present health? Excellent_____ Good_____ Fair _____

Please explain_____

Medication taken at this time (if yes, type)?_____

Does your child have allergies?_____ If yes, what kind?_____

Is there a history of ear infections?_____ If yes, list frequency_____

Has your child ever had any head injuries (loss of consciousness), seizures, hospitalizations or surgery?_____ If yes, please explain_____

_____

Approximate weight at birth_____ Months Carried____Kind of Delivery_____

Mother's age at delivery_____ Health during pregnancy_____

Describe any complications during pregnancy or birth_____

_____

Describe your child's health during and after delivery_____

_____

Describe your child as a baby_____

_____

Check the items that apply to your child's behavior when s/he was an infant:

___ Frequently smiled
___ Difficult to soothe
___ Enjoyed being rocked
___ Easy to soothe
___ Cried when wet
___ Difficulty with novelty
___ Frequently cried
___ Enjoyed being held
___ Adapted easily to new situations

As a toddler, was (is) your child:

___ Independent
___ Fearless
___ Stubborn
___ Curious
___ Distractible
___ Affectionate
___ Talkative
___ Overactive
___ Compliant
___ Aggressive
___ Friendly
___ Easy to discipline
___ Angry
___ Daring
___ Quiet
___ Adaptable
___ Defiant
___ Other_____

*Please give approximate **AGES** for the following:*

Sat up____ Crawled_____Walked _____Stopped bottle/breast feeding_____Toilet trained_____

Stopped the pacifier_____ Age said first word_____ Talked in sentence_____

What language(s) does your child speak and which is primary?_____

What language(s) are spoken in the home and which is primary?_____

Religious Affiliation:_____

Where does your child sleep? _____Describe bedtime routine_____

_____

Unusual fears (describe)_____

By whom is your child usually disciplined?_____

How?_____

Usually for what reason?_____

How does your child respond to discipline?_____

Do parents differ on discipline? No_____ Yes_____ If so, how?_____

_____

_____

_____

Please mark any areas which constitute a problem for your child:

Eating_____Sleeping_____ Nightmares_____Thumb sucking ____Nail biting _____

Bedwetting_____ Wetting in clothing _____Soiling in bed_____ Soiling in clothing_____

Getting along with friends_____Self-help skills (dressing, bathing, etc.)_____

SCHOOL AND EDUCATIONAL INFORMATION

By whom was your child cared for during the daytime as an infant?_____

Age began daycare/nursery or preschool?_____ Age started Kindergarten_____

List schools your child has attended (include nursery/daycare if applicable):

Name City Grade(s) Reason for Leaving

_____

_____

_____

What kinds of grades does your child usually earn?_____

Child's scores on most recent standardized test (e.g., FSA, SAT) _____

In what school situations or subjects does your child perform best? Worst? _____

_____

Is your child in special classes? No_____ Yes____ If yes, what kind?_____

Has your child ever repeated a grade? No_____ Yes____ If yes, which grade?_____

Has your child ever received tutoring in the past?_____ If yes, for what and how long?_____

_____

Is there any family member (sibling, parent, grandparent, cousin, etc.) who presently or in the past have (or had) learning difficulties or was in special classes? _____If yes, who and what kind/type?_____

Is there any formal or suspected family history of attention difficulties? No _____ Yes _____

If yes, who and what kind/type? _____

Child's feelings about school_____

Your feelings about the school program for your child? _____

_____

_____

SOCIAL AND EMOTIONAL INFORMATION

List your child's major interest and hobbies_____

_____

Is your child involved in extracurricular activities? _____ If yes, what kind?_____

_____

Friends (how many): Male _____ Age range_____ Female_____ Age range_____

When interacting with peers, your child can be described as:

___ Withdrawn ___ Disinterested ___ Assertive ___ Aggressive
___ Friendly ___ Thoughtful ___ Leader ___ Follower

Do you feel your child is having difficulties in school?_____ At home?_____

If so, what do you consider the problem to be and when and how did it begin?_____

_____

Are there any past or present circumstances that you think could be related to your child's present difficulties?_____

_____

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)?_____ If yes, please describe_____

_____

Is there a history of physical or sexual abuse, family violence or neglect? Yes_____ No_____

If yes, please explain_____

Has your child ever seen a psychiatrist or received medication for behavior, attention or emotional problems?_____ If yes, date(s), name of prescribing doctor and medication_____

_____

Has your child ever had counseling/psychotherapy? _____ If yes, date(s), name of practice/ therapist(s)_____

_____

Has your child ever had psychoeducational or psychological testing? _____If yes, date(s), name of practice/psychologist(s) _____

_____

Has your child ever received speech, occupational or physical therapy? _____If yes, date(s), name of agency/therapist(s), and which services?_____

_____

Do any family members have (or have had) a psychological disorder or a substance abuse/alcohol problem?_____If yes, to any either above, who and what kind?_____

_____

Please list some of your child's strengths?_____

_____

Please list some of your child's weaknesses?_____

_____

Please put any other comments that will help me understand your child better_____

_____

_____

What are your goals/expectations from treatment?_____

_____

_____

Please note <u>we do not confirm appointments</u>, although we typically provide courtesy appointment reminders through email. Even in the event that you do not receive a courtesy reminder through email, you are still responsible for your appointment.

Please list your email below if you would like a courtesy reminder.

Email address (please write clearly):_____

How were you referred to our office?_____

Phone number of referral source_____

Consent for Treatment

I voluntarily agree to and give consent for treatment by Pediatric Psychology Associates for myself and/or my family members.

Signature_____ **Date**_____

Print Name_____**Relation to child**_____

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Patient Payment Responsibility and Agreement

Name of Patient_____

Please Read and Initial Each Below:

_____ I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment is due at the time services are rendered unless special arrangements have been made. Length of time for therapy sessions are 1 hour for an initial consultation and 45 minutes for follow-up sessions.

_____ Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours' advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours' advance notice, I am financially responsible for the reserved appointment at the standard therapy hourly rate. For testing and extended sessions that are not cancelled within the time frame, I am aware that I am responsible for the number of hours blocked. We may make exceptions and waive the fee at our discretion for emergency or unusual circumstances. There may be a time when your therapist may need to cancel your appointment for an emergency; we will make every effort to reschedule you in an appropriate time frame. As a courtesy, the first 2 no shows/late cancellations will be charged at $100.00 and all other no shows/late cancellations will be charged the full therapy rate.

_____ In order to provide effective treatment, consistency of attendance of scheduled appointments is important. Our office policy is that three (3) No Shows or Late Cancellations (less than 24 hours' notice) of scheduled appointments may result in termination of therapy or testing/assessments. If therapy or testing is resumed, then a credit card on file will be required and billed at the time of the cancellation or no show.

_____ In order to be flexible and responsive, many of our therapists are available for phone sessions and to speak with you at times when necessary. Please be advised, however, that all calls exceeding ten minutes will be billed in a pro-rated fashion on the basis of your session fee.

_____ I understand that charges will be added to my account for other professional services rendered. This charge will be in increments of 15 minutes and we will always discuss additional charges with you. Other professional services include extended contact via email, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian Signature_____ Date_____

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Acknowledgment of Receipt of HIPAA Privacy Notice and New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ (print name of adult patient, parent or guardian of minor), understand that as a part of my or my family's health care, Pediatric Psychology Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professions who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer (i.e., insurance) can verify that services billed were actually provided, and
- A tool for assessing quality and reviewing the competence of healthcare professionals.

I have been presented with a copy of Pediatric Psychology Associates' Notice of Privacy Policies detailing how my information may be used and disclosed under Federal and State law. I understand the contents of the Notice. Further, I permit a copy of this Acknowledgment to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply. I understand and have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this Consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this Consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this Consent or revoking this Consent, Pediatric Psychology Associates may refuse to treat me, as permitted by section 164.506 of the Code of Federal Regulations. I understand that Pediatric Psychology Associates reserves the right to change its notice and practices prior to implementation, in according with section 164.520 of the Code of Federal Regulations. Should Pediatric Psychology Associates change its practices, it will send a copy of any revised notice to the address I have provided by U.S. mail, or e-mail, if I agree.

I understand that as a part of Pediatric Psychology Associates' treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice.

Name of Patient (Printed): _____Date:_____

Patient, Parent or Guardian Signature: _____

If refused, reason for refusal: _____ Restrictions noted: _____

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Information Regarding Submission of Insurance Claims

(Only complete form if you plan to have PPA file to your insurance company-please read carefully)

Patient's Name:_____

Initial Each Below:

_____ I understand that Pediatric Psychology Associates (PPA) is offering as a courtesy to submit claims for services to my insurance company from the time my insurance information is provided and forward. I understand that I am responsible to pay for all services at the time the service is rendered. I understand that assignment of benefits will be made to the policy holder and that PPA does not accept payment directly from insurance companies. The policy holder/responsible party is responsible for obtaining any authorizations or certifications required prior to services, as well as for follow up on any outstanding claims, including resubmissions. I understand that PPA will not submit insurance claims for services rendered prior to providing PPA with my insurance information.

_____ I understand that PPA does not submit claims for testing or group therapy services. We will provide a detailed invoice once the testing or group services are completed and payment has been received. Due to the multi-disciplinary methodology utilized in the group sessions, it may not be a covered service. It is advisable for you to contact your insurance company directly to obtain a detailed explanation of your benefits and procedures for submitting claims related to group therapy or testing, including any authorizations required prior to testing.

_____ I understand that Telehealth and out of the office services (school visits, etc.) may not be covered by insurance companies. It is advisable to check with your insurance company about this service.

_____ I understand that PPA does not maintain a contracted relationship with any insurance company. Any disputes regarding processing of claims for services are the responsibility of the policy holder.

_____ Kindly accept a photocopy of this authorization as if it were an original executed authorization. I authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims.

_____Insurance policies often change coverage especially during the yearly renewal. I am responsible for informing PPA of any changes to my policy or if I have a new insurance carrier or no insurance at all. There have been times when failure to inform our office has resulted in lack of payment from the insurance company.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian Signature_____

Printed Name:_____ Date_____