PEDIATRIC PSYCHOLOGY
ASSOCIATES

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

Dear Patient/Parent/Caregiver:

Welcome to our practice. Attached are several forms to fill out and sign to help us gather information regarding you and your family. Also enclosed are documents containing summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The law requires that we provide you with a Notice of Privacy Policies (which is attached) and obtain your signature acknowledging that we have provided you with the information.

We encourage you to complete these forms prior to your first appointment and forward to info@mailppa.com or fax to (305) 936-1022. If you are unable to, please bring them to your first appointment.

Every member of our professional and support team has been chosen for their caring attitudes as well as their professional credentials. If you should have any questions, do not hesitate to contact us.

Warmest Regards,

Pediatric Psychology Associates

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CHILD INTAKE/HISTORY FORM

Child's Name_____ Date_____

Age_____ Birthdate_____ Birthplace_____

Grade_____ School_____ School Ph#_____

Home Street Address_____

City_____ State_____ Zip Code_____

Home Ph#_____ Alternate Ph#_____

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

If parents are living apart (separated or divorced) is other parent aware that you are seeking psychological services for your child? _____ *Please list other parent's information below*:

Name and Best Contact Number_____

Street Address_____

City_____ State_____ Zip Code_____

Please note that we provide courtesy appointment reminders through email.

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

Email address:_____

If you do not have an email account, we may be able to offer a courtesy reminder call. If so, what is the best number for a courtesy reminder call?_____

How were you referred to our office?_____

Phone number of referral source_____

PRESENTING PROBLEM

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_____Business Phone Number_____

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

Father's Name_____Age_____ Birthdate_____

Occupation:_____ Education_____

Cellular_____Business Phone Number_____

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

If child is not living with both biological/adoptive parents, please describe living and 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:_____

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

Date of last medical checkup?_____ What were the findings?_____

_____

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

Please explain_____

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

As a toddler, was (is) your child:

___ Independent	___ Talkative	___ Angry
___ Fearless	___ Overactive	___ Daring
___ Stubborn	___ Compliant	___ Quiet
___ Curious	___ Aggressive	___ Adaptable
___ Distractible	___ Friendly	___ Defiant
___ Affectionate	___ Easy to discipline	___ 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., FCAT, 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 which 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?_____

_____

_____

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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HIPAA Notice of Privacy and Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review this document carefully and keep it for your records.

Introduction

At Pediatric Psychology Associates, we are committed to treating and using health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice is effective June 1, 2005, and applies to all Protected Health Information as defined by Federal Regulations.

Understanding Your Health Record/Information

Each time you visit Pediatric Psychology Associates, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communicating among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer (i.e., insurance company) can verify that services billed were actually provided,
- Source of information for public health officials charged with improving the health of the State and the Nation, as required by law (i.e., reporting child abuse and neglect or reporting domestic violence),
- Basis for disclosing your child's health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, and other law enforcement purposes,
- Source for public safety. We may disclose your child's health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public, and
- Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Pediatric Psychology Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Health Information Practices upon request,
- Inspect and copy your health record, as provided for in 45 CFR 164.524,
- Amend your health record, as provided for in CFR 164.528,
- Obtain an accounting of disclosures of your health information, as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.

Our Responsibilities

Pediatric Psychology Associates is required to:

- Maintain the privacy of your health information,
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice, provided those changes affect your health information, to you at the address you have supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization, according to the procedures included in the Authorization.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Pediatric Psychology Associates at (305) 936-1002. If you believe your privacy rights have been violated, complaints should also be directed to Pediatric Psychology Associates. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint with either, Pediatric Psychology Associates or the Office of Civil Rights.

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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 is offering as a courtesy to submit claims for services to my insurance company. 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 Pediatric Psychology Associates does not accept payment directly from insurance companies. The policy holder/responsible party is responsible for obtaining any authorizations/certifications required prior to services, as well as for follow up on any outstanding claims, including resubmissions.

_____ I understand that Pediatric Psychology Associates 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 evaluations, including any authorizations required prior to testing.

_____ I understand that Pediatric Psychology Associates 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 Pediatric Psychology Associates 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_____