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 (HIPAA), 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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MULTI-DISCIPLINARY DEVELOPMENTAL CLINIC
CHILD INTAKE/HISTORY FORM

Child's Name_____ Date_____

Age_____ Birthdate_____ Birthplace_____

Home Street Address_____

City_____ State_____ Zip Code_____

Home Ph#_____ Alternate Ph#_____

Email Address(es):_____

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*:**

Name and Best Contact Number_____

Street Address_____

City_____ State_____ Zip Code_____

How were you referred to our office?_____

Phone number of referral source_____

Do you have any concerns about your child at this time? No_____ Yes _____ If yes, please explain

_____

_____

_____

_____

FAMILY INFORMATION

Mother's Name_____Age_____ Birthdate_____

Occupation:_____ Education_____

Cellular_____ Email:_____

Father's Name_____Age_____ Birthdate_____

Occupation:_____ Education_____

Cellular_____ Email:_____

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

_____

_____

Siblings

Name Sex Age School/Occupation

_____

_____

_____

Other Persons in the Home

Name Age Relation

_____

_____

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_____

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

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

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

Approximate weight at birth_____ Weeks 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_____

_____

Did your child require extended hospitalization following birth (i.e., NICU)?_____

Check the items that apply to your child's behavior as 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

Check the items that apply to your child's behavior as a toddler (if applicable):

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

*Is your child doing the following? If so, please give approximate **AGES** when he/she:*

Motor	Language
Sat up_____	Said first word_____
Crawled_____	Babbling_____
Walked _____	Talked in sentence_____

How many words is your child using at this time?_____

If he/she is not yet verbal, how does he/she communicate needs?_____

_____

Does your child use gestures to communicate (e.g., wave bye-bye, point, blow kisses)?_____

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

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

Feeding

Is (was) your child bottle/breast fed?_____ If breast fed, until when?_____

Does he/she use a pacifier?_____ Is your child toilet trained(ing)?_____

Does your child eat solid foods?___ Can he/she eat independently? ____ Finger foods or utensil?___

Where does your child sleep? _____Describe bedtime routine_____

_____

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

Eating_____Sleeping_____ Nightmares_____Thumb sucking/Mouthing objects__ _____

Interest in peers_____Self-help skills (feeding, etc.)_____Excessive drooling_____

Has your child ever had a developmental evaluation? _____If yes, date(s)_____

Agency or name of doctor/therapist(s)_____

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

Agency or name of therapist(s)_____

By whom is your child cared for during the daytime?_____

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

Name City Age(s) Reason for Leaving

_____

_____

How does your child behave in daycare?_____

SOCIAL AND EMOTIONAL INFORMATION

What does your child enjoy doing? How do you know he is enjoying this activity?_____

_____

Is your child in extracurricular activities (Gymboree, Mommy & Me, Music)? _____ If yes, what kind?_____

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

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

_____

Unusual fears (describe)_____

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 any family member (sibling, parent, grandparent, etc.) who presently or in the past have experienced the following (check if it applies):

____ Learning difficulties ____ Attention difficulties ____ Behavior difficulties
____ Special classes ____ Developmental delay ____ Speech delay
____ Emotional difficulties (e.g., depression, anxiety)

If yes, who and what kind/type? _____

History of physical or sexual abuse, family violence or neglect? Yes_____ No_____

If yes, please explain_____

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 this evaluation?_____

_____

Consent for Treatment

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

Signature_____ **Date**_____

Print Name_____**Relation to child**_____

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MDDC Evaluation
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.

_____ Due to the multi-disciplinary nature of this evaluation, a deposit of 50% of the total evaluation cost will be collected at the time the evaluation appointment is made, as we will need to ensure that the entire multi-disciplinary team is available during the time specified. This deposit will be applied towards the total balance due at the time services are rendered. Please note that cancellations made with less than 72 hours (3 business days) of notice will not be entitled to a refund of this deposit.

_____ 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 of scheduled appointments may result in termination of services.

_____ 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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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PSYCHOLOGICAL RECORDS AND PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **DOB:** _____

I, undersigned, voluntarily request and authorize the personnel at Pediatric Psychology Associates (PPA) to obtain from and/or release to the agency(ies)/individual(s) I have indicated below the information contained in my and/or my family's clinical and medical record. I authorize PPA to release and/or obtain this private information verbally, in writing and/or electronically. I understand the purpose of the release/sharing of information may include clinical information, treatment planning, consultation, protection of self or others, coordinating interventions, educational planning, billing and collections, etc.

Check all that apply: I hereby authorize PPA _____ to release to and _____ to receive information from:

Name/Agency	Contact Information (address, phone, email, fax, etc.)

I authorize PPA to (check one):

[ ] Release any or all medical records

[ ] Release specific information- please list here_____

_____

This authorization shall expire on (please check the box that applies):

[ ] Date ____/____ /_____ [ ] Treatment Termination [ ] No Expiration Date

By signing below, I agree to the exchange of the above information. I acknowledge that the nature of this information has been discussed with me in a manner that I understand, and that I have had an opportunity to have any questions regarding the above exchange of information explained to me. I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations. I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to one of PPA's offices.

Signature of Patient/Authorized Representative _____

Printed Name of Signer _____ 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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Teletherapy Policies and Procedures

Pediatric Psychology Associates provides Teletherapy Services to individuals and families to supplement in-office sessions, as well as to individuals that may have transportation or scheduling conflicts to attend sessions in the office. In the event that you or your family decides to use our Teletherapy Services, this document has been provided to you to outline our procedures for those services. It contains instructions on how to connect with your therapist for your teletherapy sessions, along with important information about Pediatric Psychology Associates' Teletherapy Polices. ***Please read this document completely and save it for your records.***

1. Pediatric Psychology Associates uses Doxy.me (**www.doxy.me**) for its Teletherapy Sessions. The program is accessible through a web browser on your computer or a free app download on mobile devices. Doxy.me is HIPAA compliant and easy to use. When you schedule your teletherapy appointment, you will be given the "Waiting Room" web address for your therapist. This will be the address you will use every time you have a teletherapy session. You may access the waiting room at any time, and your therapist will be able to see that you have connected. At the time of your appointment, your therapist will initiate the teletherapy session. Please note that your computer or mobile device will require internet connection, a webcam, and a microphone.

2. In the case of a disconnection, you should attempt to reconnect to your therapist's doxy.me Waiting Room. If reconnection is not possible, please call the office at 305-936-1002 and your therapist will either resume your session via phone or may choose to reschedule the appointment.

3. The convenience of teletherapy sessions along with our tendencies to multitask while communicating via technology often leads patients to see teletherapy sessions differently than an in-office visit (e.g. try to get their session done "on the go" or while doing other things). Approaching a teletherapy session in this manner frequently leads to distractions, interruptions during the session, loss of privacy, and an overall reduction in efficacy of treatment. **It is very important that you treat your teletherapy session just the same as an in-office visit.** That means that you will need to be in a quiet, private place that is free of distractions and interruptions. If at the time of your session your therapist finds that you are not in a suitable location for the appointment, he or she may choose not to continue with the session, at which point you would be responsible for payment for the session as though it were a no-show.

4. Your therapist is not permitted to conduct teletherapy via any means other than Doxy.me (i.e. Skype, FaceTime, etc.) as these do not meet our required criteria for HIPAA compliance.

5. Because you are not physically in the office to remit payment, arrangements for payment for Teletherapy Sessions must be made in advance of the session.

If you have any questions regarding our Teletherapy Policies and Procedures, please do not hesitate to discuss them with your therapist or to give us a call at the office.

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Telehealth Services Agreement and Informed Consent

I _____(patient/guardian name/s) hereby consent to participating in Telehealth Services with *Pediatric Psychology Associates* (PPA).

Telehealth services are defined as communication between yourself and our practice via telephone, email, text message, video conferencing, or any other remote means that utilizes electronic transmitting technology. This includes what is defined as "teletherapy" (psychotherapeutic intervention done remotely via videoconferencing or telephone), as well as use of technology for administrative purposes (e.g. emails and phone calls regarding scheduling appointments). I understand that Telehealth allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment. This Consent Form covers all forms of electronic communication (teletherapy and administrative). I have read and understand the following important information regarding Telehealth Services:

1. I have a right to confidentiality with telehealth services under the same laws that protect the confidentiality of my medical information for in-person psychotherapy, as noted in PPA's Informed Consent Form.
2. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective, and this includes Telehealth Services.
3. I understand that Telehealth Services risk technological failure that could cause distortion or complete disruption.
4. I understand that if my therapist believes Telehealth Treatment Services (e.g. psychotherapy via videoconferencing) are not an appropriate intervention, he/she will make an appropriate referral for services they judge to be more appropriate for my circumstances. This may include a referral for in-person treatment.
5. I have the right to withhold or withdraw this consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
6. I understand that PPA uses HIPAA compliant methods for Telehealth Services. However, no use of technology can be 100% protected. I also understand that the confidentiality of any text messages, emails, or voicemails I choose to keep is my responsibility and not the responsibility of PPA.

_____	_____	_____
Client/Guardian Printed Name	Client/Guardian Signature	Date

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Credit Card Payment Consent Form

Patient Name:_____

Parent/Guardian:_____

Please charge my credit card (check one):

_____ One time only in the amount of $_____

_____ Recurrent charges after every service and for any outstanding balances.

Type of Card: □ Visa □ MasterCard □ AMEX

Cardholder's Name (as printed on card):_____

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____ CVV Number _____ 3-digit # **back** of the card (AMEX 4-digit # front of card)

Card Holder's Billing Address for Credit Card Statements:

Street Address:_____

City:_____ State:_____ Zip Code:_____

Best Contact Phone Number :_____

Best Contact Email address:_____

Signature _____ Date ____ /____ /____