P.A.T. Kids
Pediatric Advanced Therapy

Checklist for Social Work

___ Completed Intake Paperwork

___ Previous Social Work Information

___ Allergy Notification

___ Current school patient attends _____

___ Current copy of IEP for patients 3 years and older

___ Check here if patient does not have an IEP

___ Copy of Insurance/Medicaid Card

P.A.T. Kids
Pediatric Advanced Therapy

_____ is scheduled for

a(n) ____OT/PT/Speech/Social Work Evaluation__on_____

at _____ with _____.

DIRECTIONS TO OUR CLINICS

Please print, complete fully, and bring this new patient packet with you to the evaluation.
Please bring your child's insurance and/or Medicaid card with you.
Please bring a copy of your child's IEP, if applicable.
*****Please bring any past evaluations your child may have.*****

PLEASE FOLLOW THE DIRECTIONS BELOW! (MapQuest and GPS are not always accurate in locating our offices!)

PAT CLINIC, MOORESVILLE, NC LOCATION

From Charlotte: Take I-77 North to exit 36. At top of ramp, turn right onto Hwy. 150 East.
From Statesville: Take I-77 South to exit 36. At top of ramp, turn left onto Hwy. 150 East.

You will go past the Walmart on the right, and Belk and Kohl's on the left.
At next traffic light, turn left onto Corporate Center Dr. (by Zaxby's).
At stop sign, go straight onto Upper Crest into Talbert Pointe Business Park.
At stop sign turn left onto Overhill Drive (by AcroFitness).
Turn right onto Infield Court. We are located at the bottom of the cul de sac.
134 Infield Court Mooresville, NC 28117

JOHANNA'S OFFICE, MOORESVILLE, NC LOCATION

125 East Plaza Drive; Suite 118
Mooresville, NC 28115

PAT CLINIC, CHARLOTTE, NC LOCATION

2520 Whitehall Park Drive Suite 350
Charlotte, NC 28273

IMPORTANT: ALL PAPERWORK MUST BE COMPLETED BEFORE YOUR CHILD'S EVALUATION!

704-799-6824 Fax: 704-799-6825 www.pediatricadvancedtherapy.com

INSURANCE PAYMENT ESTIMATES:

The benefits quoted to us by your insurance are as follows*:

You are financially responsible for:

☐ $_____ Individual Deductible

☐ $_____Family Deductible

****The evaluation will cost approximately $_____. If you have NOT yet met your deductible (either individual or family), treatment sessions will approximately be $_____ until the deductible is met. Once met, each visit should be about $_____ per session.****

*Self-pay rates (if not filing to insurance): Please see following page.

☐ $ _____ Co-pay

☐ _____ % Co-insurance

☐ $0 due because your child has Medicaid

☐ Your plan is limited to ___visits per _____year_____.

☐ No visit limit.

Other:

_____

_____

_____

Payment is expected at the time of service.

We accept cash, check, discover, visa or mastercard.

Notice of Privacy Practices is on the back side of this sheet for your records.

** This information was given to us by your insurance company. You should also call your insurance company to verify your benefits. Discrepancies should be taken up with your insurance company, not PAT. These are just estimates and until we receive the Explanation of Benefits from your insurance company, we are unable to predict exact payments.*

IMPORTANT: ALL PAPERWORK MUST BE COMPLETED BEFORE YOUR CHILD'S EVALUATION!

P.A.T. Kids
Pediatric Advanced Therapy

Self Pay Rates (if not filling through insurance)

In Clinic Evaluation: **$90.00**

In Clinic Counseling: **$80.00 per session**

In Clinic Family Counseling without child: **$50.00 per session**

In Home Counseling Evaluation: **$95.00**

In Home Counseling: **$95.00 per session**

In Home Family Counseling without child: **$75.00 per session**

In Clinic Group Therapy: **$30.00 per session**

IEP Meeting: **$150.00/per hour** (includes IEP prep & one on one session with parents prior to IEP Meeting.)

Payment is expected at the time of service.

We accept cash, check, Discover, Visa or Mastercard.

Automatic Debit and Credit Authorization Form

This form is to allow Pediatric Advanced Therapy to withdraw funds from your designated Credit Card or Debit Card to make your monthly account payments.

I hereby authorize Pediatric Advanced therapy to charge my credit/debit card indicated below on the day of each month (as indicated on my installment contract). I understand that if my card is declined Pediatric Advanced Therapy will continue to run the authorized payment request daily until funds are available and the payment has been posted to my account.

This authority is to remain in full force and effect until Pediatric Advanced Therapy has received notification from me (or either of us) of its termination or until my account balance has reached zero.

My first payment of $_____ will be debited on _____ and every payment thereafter will be debited on the _____ day of the month.

Credit Card: _____ Visa ____ MasterCard

Other

Name on Card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: ___ / ___ Security Code: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____

Parent/Guardian Name: _____

Signature _____

Date: _____

Dear Parent(s) or Guardian(s),

Pediatric Advanced Therapy is committed to providing you and your family with the best possible care. Please understand that our office policies are in place to ensure that we are able to continue to provide excellent care to all of our patients. Your understanding of these policies is a vital piece to your child's progress in treatment, and we invite you to ask if you have any questions at any time.

As a courtesy for our patients' families, we will call your insurance carrier before treatment begins to verify coverage and benefits. The information we obtain is not a guarantee of payment; your insurance will process the claims based on your specific policy, medical necessity, and any exclusions or limitations attached to your plan. It is important that you understand that you will be responsible for any charges not covered by your insurance plan including—but not limited to—deductible, co-insurance, and co-payments. In addition, many insurance plans have a maximum number of therapy visits covered per year, with anything in addition being the responsibility of the patient. We do have a reduced, self-pay rate that we will apply if/when this occurs.

I have read and understand the financial policy for Pediatric Advanced Therapy and agree to be responsible for any charges accrued on my account. I agree to keep my account current by either paying at the time of service or within 30 days of invoice. I understand that a member of the office staff will always be available to answer any questions I may have regarding my account.

Attached you will find the information we received from your insurance company, with a quote of expected benefits and patient out-of-pocket portions.

Printed Name Signature Date

Has your child received services anywhere else? Y or N
If yes…

When:_____
Where:_____
Which therapy:_____
Discharged: (Y or N)
Date of discharge:_____

Is the child receiving services right now (including school)? (Y or N)
If yes…

Where:_____
Name of therapist:_____
Which therapy:_____
How many times a week:_____
If school, what day of the week:_____

Do you authorize Pediatric Advanced Therapy to contact other providers? (Y or N)
If yes, please sign the consent form attached.

CONSENT FOR THE RELEASE & EXCHANGE OF INFORMATION

I give permission for the exchange of information (verbal and/or written) regarding my child,

_____,
(Child's Name)

to be shared between Pediatric Advanced Therapy and

_____
(Name/Position)

_____
(Agency/School)

_____
(Address/Phone)

I understand that unless otherwise indicated, this information will be used only for treatment or educational purposes such as assessments, curriculum programming and coordination of services. I also understand that the agency receiving this information will be responsible for the confidentiality of this information.

_____
(Parent)

_____
(Date)

IMPORTANT!

Please arrive 15 minutes **before** your scheduled appointment.

ALL paperwork must be completed prior to your appointment and turned in at the window upon arrival.

What to Expect During the Evaluation

- Please arrive 15 minutes before your scheduled appointment with all of your paperwork completed.
- Our front office staff will discuss your insurance with you upon arrival if it has not already been discussed over the phone.
- Your evaluating therapist will review your paperwork and come greet you in the lobby.

During the evaluation:

- Parents are welcomed to come back into the treatment rooms during the evaluation to speak with the evaluating therapist.
- Please share your concerns for your child, medical and developmental history as well as challenges that occur within your daily routine. It is helpful to know how they do in a variety of settings as well, not just at home with you, i.e. school, play dates etc.
- Please share any precautions or limitations your child may have with regard to physical movement, environmental or food allergies.
- The evaluating therapist will complete structured and unstructured clinical observations of your child's movement patterns, sensory processing and age appropriate skills.
- The evaluating therapist will most often provide questionnaires for you to complete during your time and at this point may ask you to fill these out in the lobby while they complete additional standardized testing in a small room at a table (where appropriate). Parents are always welcome to stay for the duration if they prefer and with younger children and infants, that is typical.
- At the end of the evaluation, your therapist will share with you deficits that have been noted and decide whether or not your child requires skilled therapy intervention.
- If therapy is required, it is best to discuss days and times with the office staff before you leave so that they can begin working to find you an appointment time.
- Before you leave, you will receive educational handouts about what to expect from treatment as well as basic information regarding your child's specific difficulties.
- Your therapist will compile test scores and a written report with treatment goals.
- You can expect a report to be mailed to you within 2 weeks or sometimes it will be given to you at your next appointment.

If you have any questions, please feel free to call and ask prior to your appointment, or you can ask the evaluating therapist or office staff upon arrival. We look forward to working with you and your child to help them reach their full potential!

Sincerely,
The PAT Staff

Date: _____

NEW CLIENT INFORMATION

Referred by: _____

Welcome to Pediatric Advanced Therapy (formerly Integrative Therapy Concepts)

We look forward to working with your child. Please provide us with the following information:

Client's Name: _____ _____ _____

First M Last

Client prefers to be called: _____ Date of birth: _____/_____/_____

Parents' names(s): _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Home address: (if using a PO Box, you must also list a physical address) _____

City: _____ State: _____ Zip Code: _____

Patient's School Name & Current Grade: _____

Emergency contact: _____ Phone#: _____

Relationship to client: _____

Pediatric Physician & Practice: _____Phone#: _____

ACKNOWLEDGEMENT and ASSUMPTION of RISK

I acknowledge and agree to have my child (or the child under my care), receive occupational therapy services from Pediatric Advanced Therapy. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Pediatric Advanced Therapy and its staff, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belonging.

MEDICAL TREATMENT RELEASE:

In the event of an emergency situation at Pediatric Advanced Therapy, I give the staff of PAT my permission to initiate emergency medical services for the child listed above if I am not present during the emergency. My hospital preference is _____, however I acknowledge that Pediatric Advanced Therapy will not be held responsible for hospital or EMS providers designated.

Please note: If your child has any of the following conditions it is <u>mandatory</u> that you remain on the premises during his or her therapy session. These conditions include: Seizures, severe allergies, significant behavioral issues, and any condition that requires medicine to be controlled. This is for the safety of your child and the protection of our staff.

(1) PRIMARY INSURANCE COMPANY: _____ Phone #: _____

ID# _____ Group # : _____

Policy Holder: _____ Date of birth: _____/_____/_____ Employer: _____

(2) SECONDARY INSURANCE COMPANY: _____ Phone #: _____

ID# _____ Group # : _____

Policy Holder: _____ Date of birth: _____/_____/_____ Employer: _____

ASSIGNMENT OF INSURANCE TO PEDIATRIC ADVANCED THERAPY:

I authorize direct payment of medical benefits to Pediatric Advanced Therapy. The benefits referred to herein would be payable to me (policy holder) if I did not make assignment and include Major Medical Insurance. **I understand that I am personally responsible to Pediatric Advanced Therapy for any and all payments not covered by the insurance companies, such as co-payments, co-insurance, deductibles and denied services. All payments are due at the time of service.**

The attending therapist is authorized to release any medical information required in the administering of applications for financial coverage for service required. He/she may also send the results of the evaluation and recommendations to my referring physician for coordination and continuity of care. I have carefully completed this form and to the best of my knowledge it does not contain any false, incomplete or misleading information.

Signature: _____ Date: _____

PLEASE COMPLETE THE BACK SIDE/NEXT PAGE!

POLICIES & PROCEDURES *Revised 2/4/2015*

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at Pediatric Advanced Therapy. We are required by law to inform you of the "class of persons" who will have access to your medical information in order to carry out their job duties. This would include our therapy staff, administrative & billing staff and management. We may use and disclose your medical information for the purpose of treatment, payment and health care operation activities.

All evaluations usually last for one hour. It is the responsibility of the parent/guardian to bring all pertinent information to the evaluation. This includes your completed paperwork, insurance card, Medicaid card, and any medical history and/or past evaluations your child has received. You will need to be present for the first 20 minutes of the evaluation so that the therapist can ask you some questions. The remainder of the evaluation time will include clinical observation and in most cases, standardized testing. For liability reasons, we can only allow the children who are being treated into the gym and therapy rooms. **Siblings MUST stay in the lobby, NO EXCEPTIONS.**

Occupational and Physical Therapy sessions last for 50 minutes. Following the session is a 10 minute window to discuss your child's therapy with the therapist. It is mandatory that you are in the lobby during this 10 minute time frame. Please have your child use the restroom prior to the treatment session. Speech Therapy evaluations last for one hour and treatment sessions are 30 minutes.

If you leave the clinic while your child is in session, you **MUST** leave a phone number where you can be reached. You must return to the clinic before your child's session ends. This allows time for the therapist to speak with you regarding your child's treatment and progress, and also keeps the next client's session on schedule. **Please note: If your child has any of the following conditions it is <u>mandatory</u> that you remain on the premises during his or her therapy session. These conditions include: Seizures, severe allergies, significant behavioral issues, and any condition that requires medicine to be controlled. This is for the safety of your child and the protection of our staff.** If you arrive late for your session, your appointment will still end at the original end time.

Please try to give 24 hour notice when cancelling an appointment. (Occasional last minute emergencies are understood.) If you call after hours, please leave a message on our answering machine. Frequently cancelled appointments (3 within a 6 week period) will be basis for removal from our permanent schedule. When we establish a treatment plan for your child, we base our goals on the child having consistency. If your child misses appointments, they will not meet their goals as quickly, and your child will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. Medicaid and insurance companies require us to report attendance and show progress towards goals. In the event that you do have to cancel, we strongly encourage you to schedule a make-up appointment, even if it is with another therapist. It is often beneficial for your child when another therapist treats him or her because it gives the regular attending therapist another opinion or ideas for your child. Our staff is always in close communication with each other.

In the event that the therapist needs to cancel, we will reschedule your child with another therapist for continuity of treatment.

Failure to cancel or to appear for an appointment is considered a "NO SHOW." We will charge a $25.00 fee for "NO SHOW" appointments. After 3 "NO SHOW" appointments or late cancellations your appointment spot will be terminated. Please see our attached cancellation policy for further details.

At Pediatric Advanced Therapy, we will file with your insurance company as a courtesy. It is important for you to understand that when we contact your insurance company to verify benefits, they are only providing us with a quote. You should also call your insurance company to verify your benefits and check your benefits in your plan booklet. Many insurance plans have a limited number of visits for outpatient therapies. It is your responsibility to keep track of the number of visits your child has used. **Verification of coverage is NOT a guarantee of payment. Benefits and payment will be determined by your insurance company once the claims are received.** Any payments not covered by insurance or Medicaid will be the sole responsibility of the parent/guardian.

<u>All payments are due at the time of service.</u> We are required under contractual agreements with insurance companies to collect co-payments at the time of service. If you have a deductible that has not been met you should be prepared to pay the full allowable amount at each visit until your deductible is met. (*For example, if you have a $500 deductible, this means that your insurance company will not pay any money towards your medical expenses until YOU, the member, have spent $500 of your own money towards medical expenses.)*

- ⇨ ***I understand that I MUST return 10 minutes before my child's session ends.*** _____ (please initial here)
- ⇨ ***I understand that I will be billed for "NO SHOW" and late cancellation appointments.*** _____ (please initial here)
- ⇨ ***I agree to the payment terms listed above.*** _____ (please initial here)

I have read the Policies & Procedures listed above and have received a Notice of Privacy Practices from Pediatric Advanced Therapy.

Signature of parent/guardian: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

PURPOSE: This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. **Please read carefully.**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at Pediatric Advanced Therapy. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to maintain the privacy of protected health information. This notice will tell you about the ways we may use and share medical information about you.

USE AND DISCLOSURE OF MEDICAL INFORMATION: Following is a list of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written information you provide may be revoked at any time by writing to us.

- **FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. We may discuss medical information about your child with interdisciplinary staff at Pediatric Advanced Therapy to improve their overall care.
- **FOR PAYMENT:** We may use and disclose your medical information for payment purposes.
- **FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.
- **ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Court orders and Judicial and Administrative proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others. We may also share medical information when necessary to help law enforcement officials capture a person who admitted to being a part of a crime or has escaped from legal custody.

Health Oversight Committees: We may disclose medical information to an agency providing health over sight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

YOUR INDIVIDUAL RIGHTS:

You have a right to:

- Look at or receive copies of your medical information.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified expectations.
- Receive your own confidential health information by alternative means or alternative locations.
- Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with an explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include any changes in any future sharing of that information.

In each case, you must make your request in writing to the Privacy Officer at Pediatric Advanced Therapy.

QUESTIONS AND COMPLAINTS: If you have any questions about this notice or if you think that we have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. This complaint must be filed within 180 days of when the complainant knew or should have known that the act had occurred. The secretary may waive this 180 day time limit if good cause is shown.

This notice is effective April 14, 2003.

I have received and understand the Privacy Practices of Pediatric Advanced Therapy.

Child's Name: _____Parent/Guardian Signature: _____ Date: _____

Pediatric Advanced Therapy will be collecting video and photograph records of your child's performance during therapy sessions for their electronic medical record. I understand and consent, as this will benefit their therapy program.

Signature of Parent/Guardian: _____

Date: _____

Additional Options

I consent for photographs/videos to be used in office for staff wide trainings: Y/N

Signature: _____

I consent for photographs/videos to be used for research: Y/N

Signature: _____

I consent for photographs/videos to be used for media purposes (i.e. marketing/website): Y/N

Signature: _____

BACKGROUND QUESTIONNAIRE

(This form is intended to be completed by the child's parents or primary caregivers)

Child's Name: _____ Today's Date: _____
Birth date:_____Age:____ years____months____Home Phone: _____
Address:_____
City: _____Zip:_____
County:_____Email Address: _____
Mother's Name:_____Age:____Education: _____
Office/Cell Phone:_____
Father's Name:_____Age:____Education:_____
Office/Cell Phone:_____
Other: Caregivers/Foster parents:_____Cell Phone: _____
Child resides with: _____
Person filling out this form- Name:_____Relationship to child: _____
Who **referred** this child for an evaluation? _____
Reason for referral: _____
_____

PROBLEM SEEKING SERVICE FOR:

Services Requested (please check all that apply):

- □ Group Therapy
- □ Individual Therapy
- □ Behavior Consultation/ Behavior Plan
- □ Parent Coaching
- □ IEP Support (private pay only)

Mother's Occupation: _____
Father's Occupation: _____
Parent's Marital Status:_____
If separated or divorced, how old was the child when the separation occurred?_____
What is the custody arrangement?_____

List all the people living in the child's household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, please list their names and ages:

_____
_____
_____
_____

Primary language spoken in the home: _____

PRESENTING PROBLEMS

Please list the questions you have and/or briefly describe the current difficulties for which you are seeking help:

_____
_____
_____
_____

How long has this problem been a concern? _____
What age was the child when the problem was first noticed? _____
Why do you think the problem is happening? _____
What seems to help the problem? _____
What seems to make the problem worse? _____
Has the child received evaluation or treatment for the current problem or similar problem?

□ Yes □ No

If yes, when and with whom?_____

*****Please attach copies of evaluation reports to this document**

Does the child currently have a medical, mental health or developmental diagnosis?

□ Yes □ No

If yes, please describe. _____

Diagnosis	Diagnosis By	Age

Is the child on any medications currently? If yes, please complete the table below:

Drug Name	Reason	Dosage	Started	Effectiveness	Prescribing Physician/Psychiatrist

Does the child have any allergies? Please list _____
_____
_____

SOCIAL AND BEHAVIORAL CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits:

□ Has difficulty with speech
□ Has difficulty with hearing
□ Has difficulty with language
□ Has difficulty with vision
□ Has difficulty with coordination
□ Prefers to be alone
□ Has difficulty with change/transitioning
□ Does not get along well with brothers and sisters
□ Is aggressive
□ Is shy or timid
□ Is more interested in things (objects than in people)
□ Engages in behavior that could be dangerous to self or others (describe)

_____
_____
_____

□ Has special fears (describe)

_____
_____
_____

□ Has trouble making eye contact
□ Bites nails
□ Sucks thumb
□ Wets bed
□ Lies
□ Steals
□ Hoards
□ Special skills (describe)

_____
_____
_____

□ Uncertain of new situations
□ Difficulty with peer relationships
□ Fearful
□ Avoidance/fear related to school/community birthday parties (please circle)
□ Overly cautious
□ Has frequent tantrums
□ Has frequent nightmares
□ Has trouble sleeping
□ Rocks back and forth
□ Walks on toes
□ Bangs head
□ Problems with eating
□ Is stubborn
□ Is much too active
□ Has staring spells
□ Is impulsive
□ Is slow to learn
□ Gives up easily
□ Has toileting problems (describe)

_____
_____
_____

□ Routines, compulsions, obsessions (describe)

_____
_____
_____

□ Other (describe)

_____
_____
_____

EDUCATIONAL HISTORY

Please list **schools attended** (in order, ending with current school)	**From** (age and/or grade)	**To** (age and/or grade)	**Type of classroom** (e.g. regular education, regular education with resource, self-contained special education class)	**Specialized Therapies** (OT, PT, ST) in school- please describe type and frequency

Has your child ever been held back a grade? □ Yes □ No

If yes, what grade and why? _____

Does your child have an IEP or 504 plan? If so, please describe accommodations:

_____

_____

Place a check next to any particular educational problems your child currently exhibits:

□ Has difficulty with reading
□ Has difficulty with writing
□ Has difficulty with arithmetic
□ Has difficulty with spelling
□ Has difficulty with other subjects (please list):

_____

_____

□ Does not like school

Has your child ever received special tutoring or therapy **outside** of school? □ Yes □ No

If yes, please provide dates, and describe dates, type and frequency of therapy (example: speech therapy, 30 minutes

2 times per week, psychologist, once per week for an hour)

_____

_____

DEVELOPMENTAL HISTORY

During pregnancy, was the mother on medication? □ Yes □ No
If yes, what kind?_____
During pregnancy, did the mother smoke? □ Yes □ No
If yes, how many cigarettes each day?_____
During pregnancy, did the mother drink alcoholic beverages? □ Yes □ No
If yes, what and how much did she drink each day?_____
During pregnancy, did the mother use drugs? □ Yes □ No
If yes, what kind?_____
Were forceps used during delivery? □ Yes □ No
Was a Cesarean Section performed? □ Yes □ No
If yes, for what reason?_____
Was the child premature? □ Yes □ No
If yes, by how many weeks?_____
What was the child's birth weight?_____
Were there any birth defects or complications? □ Yes □ No
If yes, please describe_____
Were there any feeding problems? □ Yes □ No
If yes, please describe_____
Were there any sleeping problems? □ Yes □ No
If yes, please describe_____
As an infant, was the child overly quiet? □ Yes □ No
As an infant, did the child like to be held? □ Yes □ No
As an infant, was the child alert? □ Yes □ No
As an infant, did the child have trouble self-soothing? □ Yes □ No
As an infant, did the child require a lot of effort to gain engagement? □ Yes □ No
Were there any special problems in the growth and development of the child during the first few years? □ Yes □ No
Was there a time in the child's development when she or he seemed to lose skills? □ Yes □ No
If yes, please state age and describe: _____
The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. **(If you are not certain of the age but have some idea, write the age followed by a question mark)**. *If you don't remember the age which the behavior occurred, please write a question mark.*

Behavior	*Age*	*Behavior*	*Age*
Responded to mother		Spoke first word	
Rolled over		Put several words together	
Sat alone		Dressed self	
Crawled		Became toilet trained	
Walked alone		Stayed dry at night	
Babbled		Fed self	

MEDICAL HISTORY

Physician's Name and Contact Information: _____
Psychiatrist Name and Contact Information: _____
Neurologist Name and Contact Information: _____
Other Medical Practitioner and Contact: _____

Place a check next to any illness or condition that your child has had. When you check an item, also provide description where appropriate and note the approximate date (or age) of the illness.

Check Illness/Condition **Date(s)/Age(s)**

□ Measles_____
□ German Measles (Rubella) _____
□ Mumps _____
□ Chicken Pox _____
□ Whooping Cough _____
□ Diphtheria _____
□ Scarlet Fever _____
□ Meningitis _____
□ Encephalitis _____
□ High Fever _____
□ Injuries to head _____
□ Broken bones _____
□ Hospitalizations _____
□ Operations _____
□ Loss of consciousness _____
□ Visual problems _____
□ Allergies _____
□ Hay fever _____
□ Ear problems (disease, infection, injury, or impaired hearing) _____

Date(s)/Age(s)

□ Gastrointestinal Problems _____
□ Asthma _____
□ Dental Problems _____
□ Problems with menstrual cycle _____
□ Dizziness _____
□ Frequent or severe headache _____
□ Difficulty concentrating _____
□ Memory problems _____
□ Extreme tiredness or weakness _____
□ Rheumatic fever _____
□ Epilepsy _____
□ Tuberculosis _____
□ Anemia _____
□ Jaundice/Hepatitis _____
□ Diabetes _____
□ Cancer _____
□ High blood pressure _____
□ Heart Disease _____
□ Suicide attempt _____
□ Other _____

FAMILY MEDICAL AND MENTAL HEALTH HISTORY

Place a check next to any illness or condition that any member of the family has had. When you check an item, please note the family member's relationship to the child.

Check Condition	Relationship to Child
□ Alcoholism	_____
□ Cancer	_____
□ Diabetes	_____
□ Heart Trouble	_____
□ Epilepsy	_____
□ Intellectual Disability	_____
□ School Difficulties	_____
□ Language Difficulties	_____
□ ADHD	_____

Check Condition	Relationship to Child
□ Hearing Impairment	_____
□ Autism or Asperger's	_____
□ Obsessive Compulsive Disorder	_____
□ Down Syndrome	_____
□ Fragile X Syndrome	_____
□ Anxiety Disorder	_____
□ Depression	_____
□ Bipolar Disorder	_____
□ Suicide Attempt	_____
□ Other	_____

BEHAVIORAL AND OTHER INFORMATION

What are your child's strengths?

What are your child's favorite activities?

What are your child's least favorite activities?

Has your child ever been in trouble with the law? □ Yes □ No

If yes, please describe briefly:

What disciplinary techniques do you usually use when your child behaves inappropriately?

Place a check mark next to each technique that you use:

Check Disciplinary Technique	
□ Ignoring problem behavior	□ Redirect child's interest
□ Scold child	□ Tell child to sit on chair
□ Spank child	□ Send child to his or her room
□ Threaten child	□ Take away some kind of activity
□ Reason with child	□ Other (describe)

Is there any other information that you think would help me work with your child or your family?

****Please attach copies of any previous psychological evaluation reports, behavior plans and/or behavior data if available.**

Thank You!

Mobile Crisis Numbers and Counties

The following numbers are provided to you in the event that you are in the need of emergency services 24 hours a day, 7 days per week. Utilization of these numbers will provide you with immediate attention to address your needs as appropriate. In addition, crisis services may be obtained at the closest Emergency Department of your local hospital.

- For Cabarrus, Mecklenburg, Davidson, Rowan, Stanly, Union, Alamance, Caswell, Rockingham, Person, Orange, Vance, Warren, Davie, Stokes, Franklin, Granville and Chatham Counties:

  1-800-939-5911- Cardinal Innovations

- For Gaston, Lincoln, Catawba, Iredell, Cleveland, Surry, Burke and Atkin Counties:

  1-888-235-4673- Partners

- For Iredell, Surry and Atkin Counties:

  1-866-275-9552- Daymark- Mobile Engagement Team

I understand that these are the appropriate resources for a behavioral health emergency and that in the case of a life-threatening emergency, I should call 911.

Patient Name: _____ DOB: _____

Parent Signature: _____ Date: _____

Cancellation Policy

Effective March 2, 2018

Pediatric Advanced Therapy aims to provide the highest quality of care to all patients. In the interest of all of our patients, we are implementing a 24-hour cancellation policy effective January 1, 2017. All cancellations require 24 hours notice to avoid a cancellation fee. By implementing this policy, we will have the ability to replace cancelled appointments with patients in need and provide the best care for our collective patients.

Our policy is as follows:

1. Patients that cancel with more than 24 hours notice will not be subject to a cancellation fee. If a patient cancels more than 3 times in a 10-week period, they are subject to being removed from the permanent schedule.
2. Any patient that no shows for an appointment without a prior call will immediately be subject to a $25 no show fee.
3. Any patient cancelling with less than 24 hours' notice will be subject to a $25 cancellation fee.
   *If a patient schedules and attends a make-up session within the week of (or the week following) the cancellation, the cancellation fee may be waived.
4. If you cancel 2 weeks in a row due to sickness, we require a doctor note in order to attend next session.

If you have questions or would like to discuss your scheduling needs, please call 704-799-6824.