



6440 Dutchmans Parkway · Louisville KY 40205-3338

Phone: (502) 896-2606 · Fax: (502) 896-0487

[www.squareonemd.com](http://www.squareonemd.com) · [meds@squareonemd.com](mailto:meds@squareonemd.com)

**SQUARE ONE**  
SPECIALISTS IN CHILD & ADOLESCENT DEVELOPMENT

**New Patient Information**

Date: \_\_\_\_\_

**Personal Information**

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex:  M  F Social Security # \_\_\_\_\_

**Child's primary residence**

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Who lives in the home with this child: \_\_\_\_\_

Available Days and Times:

Home Phone Number(s): (\_\_\_\_) \_\_\_\_\_

Work Phone Number(s): (\_\_\_\_) \_\_\_\_\_

Cell Phone Number(s): (\_\_\_\_) \_\_\_\_\_

*(HIPAA CONSENT TO LEAVE MESSAGE)*

**I do give permission to leave relevant health care information on:**

Home Phone  Work Phone  Cell Phone  E-Mail address: \_\_\_\_\_

*Email communications are password secure but not encrypted and may be subject to unauthorized redisclosure or hacking.*

Mother's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birth date: \_\_\_\_\_ Years of Schooling: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birth date: \_\_\_\_\_ Years of Schooling: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parents/Guardians Are:  Biological  Foster  Adoptive  Other: \_\_\_\_\_

(Birth Name of Child, If applicable)

**Parents' Marital Status**

Unmarried  Married  Domestic Partnership  Single  Separated  Divorced  Widowed

**Legal custody Arrangement (select all that apply and attach supporting legal documentation)**

Joint Legal Custody  Joint Physical Custody  Sole Legal Custody  Sole Physical Custody

**Non-primary/secondary residential parent information: (please attach legal documentation)**

**Not Applicable** (please check if patient has no secondary residence)

**Relationship to Child:** \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email/Other: \_\_\_\_\_



**Speech Information (Children 6 and under or as applicable)**

Is/Does your child:

(0-never, 1-sometimes, 2-often/always)

- 0    1    2    understood by family/familiar listeners
  - 0    1    2    understood by unfamiliar listeners
  - 0    1    2    able to answer questions appropriately
  - 0    1    2    able to engage in conversation
  - 0    1    2    able to maintain eye contact while speaking
  - 0    1    2    able to relate stories or activities to others
  - 0    1    2    able to recall information given orally
  - 0    1    2    understand what is said to them
  - 0    1    2    repeat words, sounds, or syllables when speaking
  - 0    1    2    use complete sentences and correct grammar when talking
  - 0    1    2    understand nonverbal communication (facial expressions, body language)
- 

**Developmental History**

Please provide the date range your child has been receiving or has received any of the following:

**Psychotherapy/Counseling:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Speech/Language Therapy:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Occupational Therapy:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Physical Therapy:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Hearing Evaluation:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Diagnosis/es** (if applicable): \_\_\_\_\_

By Whom: \_\_\_\_\_

When: \_\_\_\_\_

**Hospitalizations:**

Where: \_\_\_\_\_ When: \_\_\_\_\_ For what reason: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries:** \_\_\_\_\_ When: \_\_\_\_\_ For what reason: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Tests:** \_\_\_\_\_ Where performed \_\_\_\_\_ When \_\_\_\_\_ Results \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

Medication (including Over the counter): Prescribed by Whom or indicate "over-the-counter":

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Child's Primary Care Physician:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Fee-for-Service Acknowledgement Statement**

Patient Name: \_\_\_\_\_

I understand that Square One, LLC is a fee-for-service practice and does not accept insurance payment. All payments are made by cash, check, or charge for the full amount at the time of service. **If payments are to be split between parents or other sources, all forms of payment must be present at the time of service.**

*Square One will provide an itemized statement for the family or other payment source to submit to an insurance company for reimbursement, should you choose to do so. **If there are insurance forms that you would like to request to be completed by our doctors, please include a self-addressed stamped envelope for us to return the forms to you. Square One does not fax or mail correspondence regarding reimbursement directly to insurance companies.***

I have read and understand the above stated policy.

\_\_\_\_\_  
Signature of Patient or Guardian (if patient is under 18)

\_\_\_\_\_  
Date

**Cancellation and Reminder Calls Policy**

I understand that when I schedule an appointment at Square One this time is reserved for my child and the doctors are not booked with multiple patient appointments.

I understand that I need to notify Square One at least 24 hours in advance if I need to cancel my appointment for any reason. Square One understands that illness is unpredictable. Please call as early as possible, preferably 24 hours in advance. Our no-show/same day cancellation policy is to charge for an appointment missed without adequate notice. The no-show/same day cancellation fee is the same as the amount of the scheduled appointment. Appointments cancelled outside of business hours via voicemail, email, or other notification are processed on the first business day following the notification.

If I cancel an appointment without adequate notification, I will be billed for that appointment.

**Reminder Calls**

**Square One administrative staff routinely makes one reminder call to one designated parent/guardian/patient the day prior to scheduled appointments. Square One does not make multiple reminder calls per appointment. Reminder calls are a courtesy only. If you do not receive a reminder call or if a reminder message does not reach you, our cancellation policy remains in effect.**

I have read and understand the above stated policy.

\_\_\_\_\_  
Signature of Patient or Guardian (if patient is under 18)

\_\_\_\_\_  
Date

Square One, LLC
Specialists in Child and Adolescent Development
6440 Dutchmans Parkway
Louisville, KY 40205-3338
Phone: (502) 896-2606 Fax: (502) 896-0487
meds@squareonemd.com

Authorization For Use And/Or
Disclosure of Protected Health Information (PHI)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I \_\_\_\_\_ hereby authorize and request the release of all Protected Health Information (PHI) on my child/me: \_\_\_\_\_

To or From: Square One, LLC To or From: facility

name \_\_\_\_\_

Fax: # \_\_\_\_\_ Phone consultation: # \_\_\_\_\_

Mail: address \_\_\_\_\_ City ST Zip \_\_\_\_\_

including the following (mark all that apply):

- Entire Health Record (including psychotherapy notes)
Health Record (without psychotherapy notes)
Medical Evaluation Report Psychiatric Evaluation Report Psychological Evaluation Report
Speech-Language Evaluation Report
Billing Records
Other (please list) \_\_\_\_\_

- I understand that if my protect health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be redisclosed and would no longer be protected.
I understand that this information may include information relating to Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.
I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter to Square One, LLC at the address listed on this authorization form. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty (180) days from the date of this form or on the following date or event \_\_\_\_\_.
I understand that I may refuse to sign this authorization and that Square One, LLC may not condition treatment on the completion of this authorization except as indicated in 45 CRF § 164.508(b)(4).

I certify that I have read and received a copy of the authorization. This authorization supercedes any and all previous authorizations.

Signature: \_\_\_\_\_ Date \_\_\_\_\_
(Patient or Patient's Representative)

Relationship to Patient \_\_\_\_\_
Printed Name of Patient's Representative given authority to act for patient.

**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION –  
EVALUATION REPORTS RELEASE AUTHORIZATION**

**Two copies of the evaluation report are available approximately four weeks after the initial evaluation is performed or two weeks after the parents-only consultation following the evaluation.**

- You have the option of receiving both copies or having a copy mailed to a facility authorized by you at no charge.
- It is strongly recommended that the parent/guardian photocopy the report for additional record requests made by other facilities involved in your child's care.
- A fee of \$15.00 per evaluation report shall be charged for additional copies of reports requested by parents/guardians.

**I authorize Square One, LLC to disclose medical, psychological and/or speech-language evaluation reports for the person named below:**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

to the following:

1. Name: (Parent/Guardian/Patient)

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

2. Name: (i.e. Referral Source, Pediatrician, etc)

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

As required by Kentucky law KRS 422.317: Patients/guardians are entitled to one free copy of the medical record, "A copying fee, not to exceed one dollar (\$1) per page, may be charged by the health care provider for furnishing a second copy of the patient's medical record upon request either by the patient or the patient's attorney or the patient's authorized representative."

Signature: \_\_\_\_\_ Date: \_\_\_\_\_