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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: _____

Who referred your child to Square One? (Please circle one or describe other)

Pediatrician **S**chool **A**nother Square One Family **F**riend **M**agazine **R**adio **I**nternet Search

Other: _____

Why are you requesting this evaluation? What are your specific concerns?

_____

_____

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Schooling

__Preschool __Grade School __Middle School __High School

School Currently Attending: _____

Grade Level: _____

Does your child receive special education services? __Yes __No If so, what type(s) of services?

_____

Has your child had previous education/psychological testing with a School Psychologist or Clinical Psychologist?

Date(s): _____

With Whom: _____

Address: _____

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. Monday appointments should be cancelled by end of business day the preceding Friday.

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

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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: _____