



# SQUARE ONE<sup>®</sup>

SPECIALISTS IN CHILD & ADOLESCENT DEVELOPMENT

## New Patient Information

Thank you for your interest in Square One. We hope that you will find the following information helpful in the scheduling process. If you have any questions or need additional assistance with our process, please call our office at (502) 896-2606.



### Initial Information and Questionnaires

Initial information required before scheduling an appointment are the Patient Information forms, which may be downloaded from our website, <http://www.squareonemd.com> and the Child Behavior Checklist and the Teacher Report Form questionnaires. Upon receiving the completed Patient Information forms from you, we will contact you by phone and guide you through the remainder of the process. We will arrange to mail the questionnaires (or you may pick these up from our office) to be completed by parents and a teacher or teachers and returned to us to start your child's medical record in our office. **When we receive all completed forms, questionnaires, and any other records we've requested, our doctors will review the information and we will call you to schedule the recommended appointment.**



### Previous medical records

If there have been previous developmental evaluations, psychological testing, genetic work-ups, genetic laboratory testing, MRIs, CT Scans, or EEGs, please inform us as soon as possible. You will need to obtain all records prior to your appointment. They may be faxed to our office at (502) 896-0487.



### Payment

Payment is due at the time of service. Acceptable payment types include Health Savings Account (HSA) or Flexible Spending Account (FSA) funds, most major credit cards, check, or cash. While we do not participate in any insurance plans, we will provide itemized invoices so that you may submit a claim for out-of-network benefits to your individual insurance carrier. **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.**



### The Day of Your Appointment

When your appointment is scheduled, we request that you arrive 15 minutes prior to your appointment. If you are going to be more than 15 minutes late, we request that you notify us at (502) 896-2606. Please note that we do not book multiple patients for the same time allotments: **your appointment time is uniquely for you.**



### No Show Policy

As a courtesy, our office makes reminder calls one business day before your scheduled appointment. Our no-show policy is to charge for an appointment missed without prior notification from you. The no-show fee for appointments not cancelled 24 hours in advance is the same as the amount charged for the scheduled appointment.

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 rediscovery 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 School Another Square One Family Friend Magazine Radio Internet Search

Other: \_\_\_\_\_



### Functional Communication Parent Questionnaire

Please circle 0-3 to rate how often the following statements are true about your child:

Not Yet	Sometimes	Usually	Always	
0	1	2	3	I understand my child's speech production.
0	1	2	3	Strangers understand my child's speech production.
0	1	2	3	My child stutters (repeats sounds/syllables/words/phrases, such as "b-b-butter").
0	1	2	3	It takes my child several tries to say what s/he wants to say (e.g., "I just I want it's like Mom I want juice!")
0	1	2	3	My child's voice sounds healthy, smooth, and appropriate for age and gender.
0	1	2	3	My child becomes upset when adults cannot understand or guess what s/he wants.
0	1	2	3	Words are my child's main way to communicate (gestures, vocalizations, are secondary).
0	1	2	3	My child has back-and-forth conversations with adults.
0	1	2	3	My child needs help playing turn-taking games.
0	1	2	3	My child needs reminders to use words when upset/sad/frustrated.
0	1	2	3	My child uses complete sentences and proper grammar.
0	1	2	3	My child tells easy-to-follow narratives about past events.
0	1	2	3	My child can explain games or procedures so that others can understand.
0	1	2	3	My child asks different types of questions (i.e., <i>who</i> , <i>what</i> , <i>when</i> , <i>where</i> , <i>why</i> , <i>how</i> ).
0	1	2	3	Learning new words seems easy for my child.
0	1	2	3	My child follows different sets of behavior expectations in different settings (i.e., the park, school, the library, grandma's house, etc.)
0	1	2	3	It is easy for my child to understand novel directions (e.g., "Put your shoes in the fridge and clap twice").
0	1	2	3	My child understands humor, jokes, and sarcasm.
0	1	2	3	My child understands body language (i.e., a "stop" hand signal, a conversation partner moving away, follow a point).
0	1	2	3	My child remembers things I tell him.

**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? With whom: \_\_\_\_\_

Date(s): \_\_\_\_\_

**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:
_____	_____	_____
_____	_____	_____



**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 uses an automated reminder call and text system. 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

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

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

CONSENT TO PHOTOGRAPH AND/OR VIDEO RECORD

SQUARE ONE, LLC  
6440 Dutchmans Parkway  
Louisville, KY 40205-3338  
(502) 896-2606 Fax (502) 896-0487

This consent form, if signed, will authorize Square One, LLC to photograph and/or video record the person named below. Photographs and videos will remain the property of Square One, LLC and part of the patient's medical record.

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

First: \_\_\_\_\_

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

Patient's Birthdate: \_\_\_\_\_

/ / I authorize my child (or myself and my child) to be photographed and/or video recorded by Square One, LLC. I understand that the picture/video(s) will be included in my child's medical record and will be used for no other purpose.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (Patient's Representative Given Authority to Act for Patient)

\_\_\_\_\_  
Relationship to Patient