SQUARE ONE®
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:

Email Address: _____

Work Phone Number(s): (____)_____ _____

Cell Phone Number(s): (____)_____ _____

(HIPAA CONSENT TO LEAVE MESSAGE)

I <u>do give permission</u> 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: _____

Please Indicate/list if there was a specific clinician(s) you were referred to at Square One:

_____

Please describe reasons and concerns for why you are requesting services for you child:

Functional Communication Parent Questionnaire

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

Not Yet	Some-times	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., *who, what, when, where, why, how*).
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:

_____

_____

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: _____

Other Important Information:

_____

_____

_____

_____

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_____

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

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: _____

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