



## Education/OT Consultation

**Square One, LLC**  
**6440 Dutchmans Parkway**  
**Louisville, KY 40205-3338**  
**Phone: (502) 896-2606 Fax: (502) 896-0487**  
[www.squareonemd.com](http://www.squareonemd.com)

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 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



**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

**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](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)

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