NEW PATIENT FORM - All Fields Required

SQUARE ONE
SPECIALISTS IN CHILD & ADOLESCENT DEVELOPMENT

Patient Name & Personal Information

LAST _____ FIRST _____ MIDDLE _____

BIRTH DATE _____ SEX _____ SSN _____

Patient's Primary Residence

ADDRESS _____ CITY _____ STATE _____ ZIP_____

Parent / Guardian One – Name & Personal Information

LAST _____ FIRST _____ MIDDLE _____

OCCUPATION _____ BIRTH DATE _____ YRS OF SCHOOLING _____

EMAIL _____ CELL PHONE _____ AVAILABILITY:
DAYS / TIMES _____

Relationship to the patient (Select all that apply / email supporting legal documentation to Meds@squareonemd.com)
BIOLOGICAL ____ STEP ____ FOSTER ____ ADOPTED ____ OTHER _____

HIPAA CONSENT TO LEAVE A MESSAGE - Email communications are password secure but not encrypted and may be subject to unauthorized redisclosure or hacking: ____I do give permission to leave relevant healthcare information on my cell phone / email

Parent / Guardian Two – Name & Personal Information

LAST _____ FIRST _____ MIDDLE _____

OCCUPATION _____ BIRTH DATE _____ YRS OF SCHOOLING _____

EMAIL _____ CELL PHONE _____ AVAILABILITY:
DAYS / TIMES _____

Relationship to the patient (Email supporting legal custody documentation to Meds@squareonemd.com)
BIOLOGICAL ____ STEP ____ FOSTER ____ ADOPTED ____ OTHER _____

HIPAA CONSENT TO LEAVE A MESSAGE - Email communications are password secure but not encrypted and may be subject to unauthorized redisclosure or hacking: ____I do give permission to leave relevant healthcare information on my cell phone / email

Parents / Guardians are:

MARRIED _____ UNMARRIED_____ SINGLE _____ DOMESTIC PARTNERSHIP_____
SEPARATED_____ DIVORCED _____ WIDOWED _____

Legal Custody Arrangement*:

JOINT LEGAL CUSTODY _____ JOINT PHYSICAL CUSTODY_____ SOLE LEGAL CUSTODY _____ SOLE PHYSICAL CUSTODY____

**Our office will need a copy of any custody agreements*

Who lives in the home with the patient: _____

If The Patient Splits Residences With Parents / Guardians, Please Provide Secondary Information

Patient's Secondary Residence:

STREET ADDRESS _____ CITY _____ STATE _____ ZIP_____

Secondary Residence Is Home To:
PARENT / GUARDIAN ONE _____ PARENT / GUARDIAN TWO _____
OTHER GUARDIAN _____ LAST NAME _____ FIRST NAME _____
EMAIL _____ CELL PHONE _____ AVAILABILITY:
DAYS / TIMES _____

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

PEDIATRICIAN _____ SCHOOL _____ ANOTHER SQUARE ONE FAMILY _____

MAGAZINE _____ RADIO _____ INTERNET SEARCH _____

OTHER _____

PLEASE LIST SPECIFIC CLINICIAN(S) YOU WERE REFERRED TO AT SQUARE ONE, IF ANY _____

PLEASE DESCRIBE REASONS AND CONCERNS FOR WHY YOU ARE REQUESTING SERVICES FOR YOUR CHILD:

_____

_____

_____

_____

_____

_____

Patient's Schooling Information

CURRENT SCHOOL _____ GRADE LEVEL _____

Does your child receive special education services? _____ YES _____ NO

If so, what type(s) of services? _____

Has your child had 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**

DATES _____ ADDRESS _____

_____ **SPEECH/LANGUAGE THERAPY**

DATES _____ ADDRESS _____

_____ **OCCUPATIONAL THERAPY**

DATES _____ ADDRESS _____

_____ **PHYSICAL THERAPY**

DATES _____ ADDRESS _____

_____ **HEARING EVALUATION**

DATES _____ Diagnosis/es _____

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Medical Information and History

HOSPITALIZATIONS: (Where, When, For what reason) _____

_____

SURGERIES: (When, For what reason) _____

MEDICAL TESTS: (Where performed, When, Results)

CURRENT MEDICATIONS: (Prescribed by Whom or indicate "over-the- counter")_____

_____

CHILD'S PRIMARY CARE PHYSICIAN

NAME_____ STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE _____ FAX _____

Pharmacy

LOCATION _____

PHONE _____

Please provide other important information_____

_____

Fee for Service Acknowledgement Statement

I understand that Square One, LLC is a fee-for-service practice and does not accept insurance payments. 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.

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 the end of business day the preceding Friday.

Square One understands that illness is unpredictable. Please call as early as possible, preferably 24hours 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. **DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.**

SIGNATURE _____ **DATE**_____

SQUARE ONE, LLC
Specialists in Child and Adolescent Development
6440 Dutchman Parkway
Louisville, KY 40205-3338
(502) 896-2606 Fax (502) 896-0487
meds@squareonemd.com

SQUARE ONE, LLC
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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 ____

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 protected 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 supersedes any and all previous authorizations.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

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

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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.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

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

PATIENT NAME_____ DATE OF BIRTH_____

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."

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CONSENT TO TREAT

If signed, I do hereby consent to any medical care determined by a provider to be necessary for the welfare of my child while said child is under the care of Square One, LLC.

PATIENT'S LAST NAME: _____ PATIENT'S FIRST NAME: _____

Parent/Guardian:

PATIENT'S BIRTHDATE: _____

PRINTED NAME (PATIENT OR PATIENT'S REPRESENTATIVE GIVEN AUTHORITY TO ACT FOR PATIENT):

_____

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

RELATIONSHIP TO PATIENT: _____

EMAIL ADDRESS: _____

SIGNED BY: _____

SIGNED ON: _____

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CONSENT TO PHOTOGRAPH

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

PATIENT'S LAST NAME: _____ PATIENT'S FIRST NAME: _____

Parent/Guardian:

DATE: _____

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.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

RELATIONSHIP TO PATIENT: _____

EMAIL ADDRESS: _____

SIGNED BY: _____

SIGNED ON: _____