



# Intake Packet – 2011

**Items needed for the initial visit:**

- Self pay payment or copayment with your insurance card
  
- If divorced, legal documents showing joint custody and/or medical decision designee

**Insurance information will be requested when we schedule your child's first appointment.**

**Do you have a family member currently being seen in our clinic?**

**If so, what practitioner(s) are they seeing?**

\_\_\_\_\_

# Child and Adolescent Behavioral Health Clinic

University of Utah Hospital and Clinics

## Clinic Policies – July 1, 2011

Dear Parents,

Thank you for your interest in having your child seen at the University of Utah Child, Adolescent, and Young Adult Behavioral Health Clinics. We are pleased that we are able to offer high quality care to the families that choose our Clinic. Our practitioners are highly trained with extensive experience in the field of Child and Adolescent Psychiatry, and are also part of the University of Utah faculty. Please take a moment to review this information before completing the packet. The information covered in this packet will allow our practitioners to provide the best possible care for your child.

### Setting an appointment

Once you have received this packet, reviewed the information, and completed the Patient Information, and Financial Responsibility please return the forms to our clinic. When we have received the packet we will call the responsible party for an appointment. No appointment will be made until we receive a completed packet. Having these completed forms will allow the practitioner to review your child's history and current symptoms prior to your child's visit. These appointments usually last between 1 1/2 to 2 hours, consisting of a diagnostic evaluation of the child and an interview with the parents. We prefer that both parents attend the initial evaluation in order to get a more complete history. Our practitioners may provide medication management, psychotherapy, and consults when requested by other physicians. Our psychologists may provide psychotherapy (individual and/or family) and psychological testing.

### Fees and Services

The Child and Adolescent Behavioral Health Clinic is primarily a self-pay clinic. This means that the full payment of service is due at check-in for each visit. We do honor a 30% discount for all self pay services at time of visit. If the University of Utah has contracted with an insurance carrier *for this specific clinic*, the co-pay will be collected at each visit. (This includes Molina CHIPs clients.) Your practitioner will supply you with a *superbill*, which is a form that can be submitted to medical insurance companies for reimbursement. Although our practitioners are not listed on medical insurance "Preferred Provider Lists," the majority of medical insurance plans provide for "Out Of Network" benefits. (Please note that our practitioners *may* be listed as providers on your insurance. However, this is most likely coverage for inpatient care. Please check with your insurance company to verify your coverage. You will be liable for the total bill, in this case.) **Our practitioners and staff will NOT complete insurance forms or call insurance companies for authorization of visits.** For more information regarding your medical insurance's "Out of Network" benefits, please contact your insurance company.

We offer a few fee schedules. This is based upon the level of training; however, all of our practitioners provide excellent care. Those providers completing their training are supervised by our attending providers.

- **Attendings:** MDs who have completed Adult Psychiatry Residency and Child and Adolescent Psychiatry Fellowship. All are board certified in both Adult Psychiatry and Child and Adolescent Psychiatry.
- **Psychologists:** PhDs who have completed graduate training and post-doctorate work in psychology. All have expertise in childhood and adolescent issues. All are board certified and licensed in psychology. These providers conduct therapy and psychological testing.
- **APRNs (Advanced Practice Nurse Practitioners):** nurses with a graduate degree in nursing with specialty in behavioral health. All are fully licensed and have practiced in the mental health field with children and adolescents. APRNs have clinical supervision with attending faculty on a regular basis.
- **Residents:** Senior level trainees, completing either a Child and Adolescent Psychiatry Fellowship (completed Adult Psychiatry Residency, board eligible) or a Triple Board Residency (Adult and Child/Adolescent Psychiatry and Pediatrics).
- **Graduate Student:** a 4<sup>th</sup> or 5<sup>th</sup> year graduate student of psychology (University of Utah) who is completing a portion of training. They have a particular interest in child and adolescent psychology and are seeking-out specific training opportunities. All are supervised (weekly) by one of our clinical psychologists.

Type of Provider	Initial Evaluation 1.5 to 2 hour visit (90801)	Eval and Med. Management 30 min. appt. (90805)	Therapy 20-30 Mins (90804)	Therapy (1 hour) (90806)	Eval and Med. Mngmt (90807)	Psychology Testing (96100 96101 96117)	2 <sup>nd</sup> Opinion/Case Review (based on hourly rate) (99244)
Psychiatrist – <b>Contract rate</b>	\$640	\$173.40		\$217.43	\$240.83		\$250
Psychiatrist <b>SELF PAY- 30% discount</b>	\$448	\$121.38		\$152.50	\$168.58		\$200
APRN <b>Contract rate</b>	\$512	\$138.72	\$138.99	\$173.94	\$192.66		\$200
APRN <b>SELF PAY- 30% Discount</b>	\$358.40	97.10	\$111.19	\$121.76	\$134.86		\$140
Psychologist <b>Contract rate</b>	\$302.08		\$135	\$182.25		\$200/hour	\$200
Psychologist <b>SELF PAY</b>			\$94.50	\$127.58		\$200/hr	\$200
Resident <b>Contract rate</b>	\$302.08	\$102.31	\$79.65	\$102.62	\$113.67		
Resident <b>SELF PAY 30% discount</b>	\$211.46	\$71.62	\$55.76	\$71.83	\$79.57		
Report requests							*Billed/hour based on specialty
Letter requests							\$25
Mailing Prescriptions							<b>Bring Self Addressed Stamped Envelopes</b>

**Missed Appointments- No Shows**

For each visit, after the initial evaluation, a reminder card will be mailed of the scheduled date and time. Missed appointments or appointments not cancelled prior to 48 hours before the scheduled time will be charged the **full fee** for the scheduled service. This also applies to Diagnostic Evaluations (First Visits). This “No Show” fee will automatically be charged by the University of Utah Hospitals and Clinics. We understand that there are special circumstances that cannot be avoided (emergencies, severe weather, etc.) and such events will be taken into account. If you arrive to your appointment 15 minutes or more after your scheduled time, it will be considered a “No Show” and will have to be rescheduled for a different day.

**Prescription Requests**

Our Clinic requires **48 business hours notice for any prescription refills**. In addition, regular clinical visits are necessary to continue medication refills, as directed by your practitioner. We are happy to fill 90-day mail order prescriptions.

**Telephone Calls**

Telephone calls should be kept to a maximum of 5 minutes. If you need additional time to speak to your practitioner an appointment will be necessary.

**After Hours/Weekends**

If it becomes necessary to contact a practitioner for crisis counseling or for other emergencies, the University Neuropsychiatric Institute (UNI) is staffed at all times to assist you. The doctor on call can be contacted through the hospital operator at (801)583-2500.

**Complaints**

Any complaints or difficulties regarding the Clinic procedures, physicians, or staff, should be addressed to Josette Dorius, RN, MPH (Service Director) at (801)587-3108.

**Packet**

The enclosed information packet, along with any previous mental health records from your child's health care provider, will allow us to improve the quality of care we can offer. By contacting your insurance company early, it will enable them to more easily assist you. If you have any questions, please contact the clinic at (801)585-1212.

**We look forward to seeing you at the  
Child, Adolescent, and Young Adult Behavioral Health Clinic.**

**650 Komas Drive, Suite 208  
Salt Lake City, Utah 84108**

**Phone: (801) 585-1212  
Fax: (801) 585-9096**

# University Health Care

Child and Adolescent /  
Adult Behavioral Health Clinics

**650 Komasa Drive, Suite 208**

801-585-1212

### End Directions

Parking lot is in back (west) of building  
Enter from the West side of the building  
Take Elevator or stairs to 2nd floor  
Suite 208 is on the south end of the long hallway

Utah Transit Authority (UTA) have bus routes that come to the east side of our building, including 3, 455, 473. For more information, go to the UTA web site at [www.utabus.com](http://www.utabus.com)



### Estimated Driving Times:

From Sandy via I 215 to Foothill: 40 minutes

From Draper via I 15 to I215 to Foothill: 40 minutes

From West Jordan via 7800 South to I15 to I215 to Foothill: 45 minutes

From Magna via Highway 201 to I80 to Foothill: 40 minutes

**GIVE YOURSELF EXTRA TIME IF DRIVING IN THE MORNING: TRAFFIC IS VERY HEAVY!!**

**CHILD AND ADOLESCENT BEHAVIORAL HEALTH CLINIC  
UNIVERSITY OF UTAH HOSPITAL AND CLINICS**

<u>Last Name</u>	<u>First</u>	<u>Middle</u>	<u>Birth Date</u>	<u>Sex</u>	<u>Social Security Number</u>
<u>Home Address</u>	<u>Street</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Home Phone</u>

Is your child currently living at: (Circle) At HOME with both parents    At HOME with Mom    At HOME with Dad  
 Boarding school    Foster care    Residential placement    Other; please specify: \_\_\_\_\_  
 For divorced parents we need copies of the legal documents stating custody and/or medical decision rights.

**Mother**

**Legal Guardian** \_\_\_ Yes \_\_\_ No

<u>Last Name</u>	<u>First</u>	<u>Middle</u>	<u>Birth Date</u>	<u>Social Security Number</u>	
<u>Home Address</u>	<u>Street</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Cell Phone</u>
<u>Name of Employer</u>	<u>Complete Address</u>			<u>Work Phone</u>	
<u>E-Mail Address</u>	<u>Preferred Method of Contact</u>				

**Father**

**Legal Guardian** \_\_\_ Yes \_\_\_ No

<u>Last Name</u>	<u>First</u>	<u>Middle</u>	<u>Birth Date</u>	<u>Social Security Number</u>	
<u>Home Address</u>	<u>Street</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Cell Phone</u>
<u>Name of Employer</u>	<u>Complete Address</u>			<u>Work Phone</u>	
<u>E-Mail Address</u>	<u>Preferred Method of Contact</u>				

I have read and understand the enclosed clinic policies. The Child and Adolescent Young Adult Specialty Clinic is a self pay clinic. Payment in full is due at the time of service. A bill will be provided so that you may submit it to insurance for reimbursement. For participants in the selected contracts through the University, a co-payment will be required at the time of service. If a co-payment or service fee is not submitted on the day of service, a 10% fee will be assessed.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**FINANCE CHARGE**

I understand that the services received today and in the future will be my responsibility and not billed to a third party payer. All charges not paid in full after 60 days will incur interest at the rate of 1.5% per month (18% annum) or a repeat billing charge of \$3.00, whichever is greater. I agree to pay a \$15.00 service fee for any check returned unpaid by my bank. In the event any balance due is not paid I agree to pay all costs of collection, including but not limited to collection fees, attorney fees and court costs.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**UNIVERSITY OF UTAH HOSPITALS AND CLINICS  
OUTPATIENT CONDITIONAL AGREEMENT**

**1. TREATMENT CONSENT:**

The patient consents to treatment with the University of Utah Hospital and Clinics which includes University Hospitals and Clinics and School of Medicine Departments. Treatment may include x-ray examinations, laboratory procedures, anesthesia, medical treatment, and surgical treatment.

**2. RELEASE OF INFORMATION:**

The Hospital and Clinics may disclose all or any part of the patient's record, as part of the treatment, to the physician, and other providers concerned with the patient's care.

The Hospital and Clinics may also disclose the patient's records to any person, Social Security Administration, insurance or benefit payer, health care service plan, or worker's compensation carrier, which is or may be liable for all or any portion of the hospital's or treating physician's charges to the extent necessary to determine liability for payment and to obtain reimbursement. Further release will be governed by the Utah Government Records Access and Management Act. Section 63-2-101 et. Seq., U.C.A., 1953 as amended.

**3. ASSIGNMENT OF BENEFITS:**

The patient assigns all benefits to the Hospital and Clinics for the full amount of charges due and all rights to claims, and causes of actions, the proceeds of any insurance coverages, third party liabilities, worker's compensation, governmental agency or disability benefits, and all settlements, judgments or verdicts in favor of the patient, and the Hospital and Clinics is given a lien in like amount. I certify that the information given by me, the undersigned, is accurate to the best of my knowledge including information for applying for payments under Title XVIII or Title XIX benefits.

**4. FINANCIAL RESPONSIBILITY:**

I understand that I am financially responsible for charges not covered by my third party payers.

I agree to be financially responsible for all Hospital and Clinics charges in accordance with the regular rates and terms. If payment of all charges is not made when due (upon initial billing), I agree to pay all costs of collection for amounts due, including collection fees, attorney's fees and costs of court. All delinquent accounts may bear interest at the legal statutory rate.

**5. APPLICATION OF THE UTAH GOVERNMENT IMMUNITY ACT:**

I understand that all claims against the University of Utah Hospital and Clinics employees, including but not limited to physicians, nurses, technicians, and students, are subject to the provisions of the Utah Governmental Immunity Act, Section 63-30-1, et. seq., U.C.A., 1953 as amended, which act controls all procedures and limitations with respect to any claim of liability or malpractice.

**I HEREBY ACKNOWLEDGE THAT I HAVE READ THE AGREEMENT AND AS THE PATIENT, OR THE PERSON AUTHORIZED TO SIGN ON THE PATIENT'S BEHALF TO EXECUTE THIS DOCUMENT, ACCEPT THE TERMS AND CONDITIONS SET FORTH.**

\_\_\_\_\_  
**NAME OF PATIENT (PLEASE PRINT)**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF PATIENT OR REP.**

\_\_\_\_\_  
**RELATIONSHIP**

**Presenting Problem:**

What concerns you most about your child? \_\_\_\_\_  
\_\_\_\_\_

When did you first notice this problem?  
\_\_\_\_\_  
\_\_\_\_\_

How has this problem affected his/her functioning?  
At home: \_\_\_\_\_  
\_\_\_\_\_

At school: \_\_\_\_\_  
\_\_\_\_\_

With Friends: \_\_\_\_\_  
\_\_\_\_\_

Do you have any other concerns about your child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(for office use only)

DOB __/__/__
Name _____

**Have you recently worried that your child has:**

- Yes  No     **DEPRESSION** (sad, hopeless, poor sleep, crying, etc.)
- Yes  No     **MOOD SWINGS** (energetic, little sleep, pleasure seeking, racing thoughts, talkative, decrease need to sleep)
- Yes  No     **ANXIETY** (worries, restless, scared, poor sleep, etc.)
- Yes  No     **BEHAVIORAL PROBLEM** (fights, anger, arguing, sexually acting out)
- Yes  No     **ATTENTION/HYPERACTIVITY PROBLEM** (Poor attention, hyperactive, impulsive, etc.)
- Yes  No     **ABNORMAL EATING BEHAVIORS** (too much, too little, fears of weight, ad body image, bingeing, purging etc.)
- Yes  No     **SOCIAL ANXIETY** (shy and/or afraid to be around others)
- Yes  No     **REMEMBERING PAST TRAUMAS** (in nightmares, recurrent memories, etc.)
- Yes  No     **AUTISM** (social and language impairments, rigidity)
- Yes  No     **PSYCHOSIS** (hearing voices, seeing things, paranoid)
- Yes  No     **DISSOCIATION** (feeling outside your body or things are not real, etc.)
- Yes  No     **OCD** (recurrent intrusive thoughts, obsessive rituals, compulsions)
- Yes  No     **Tics** (motor tics, vocal tics, etc.)
- Yes  No     **Addiction** (substance abuse, pornography, video games, etc)

(for office use only)

**Past Psychiatric History:**

Please list any previous psychiatric hospitalizations, residential, or day treatment programs (also including any alcohol and drug treatment programs)

Date	Location	Diagnosis	Helpful (yes/no)

Please list any past Psychiatrists or Therapists that have treated your child

Name	Address	Phone

Please list your child's current psychiatric medications.

**Name                      Duration                      Response**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all the previous psychiatric medications which have been tried.

**Name   Duration   Response   Reasons for Stopping**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child ever harmed herself intentionally or attempted suicide (if yes, please explain)? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child harmed anyone? \_\_\_\_\_

(for office use only)

**Developmental History:**

Please indicate to the best of your memory whether the ages for the following

Milestones were D-delayed, N-within normal range, E-early:

Walks                      11-14 months                      \_\_\_D \_\_\_N \_\_\_E

First words                      11-15 months                      \_\_\_D \_\_\_N \_\_\_E

Pretend play                      12-24 months                      \_\_\_D \_\_\_N \_\_\_E

Toilet trained                      20-36 months                      \_\_\_D \_\_\_N \_\_\_E

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there problems with the following during the first 3 years of life?

- Behavior  Yes  No
- Bonding to primary caretaker  Yes  No
- Separates appropriately to caregiver  Yes  No
- Frustration/Anger  Yes  No
- Sleeping  Yes  No
- Feeding  Yes  No
- Energy level  Yes  No
- Aggression  Yes  No
- Adjustment to change  Yes  No

(for office use only)

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please describe, to the best of your memory, whether the ages for the following milestones were D-delayed, N-within normal limits, E-early:

- Speaks full sentences      2-3 years       D  N  E
- Rides a tricycle            2-3 years       D  N  E
- Plays cooperatively        4-6 years       D  N  E
- Writes letters/numbers    4-6 years       D  N  E
- Uses scissors                4-6 years       D  N  E

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Did your child have behavior problems in preschool?  Yes  No

If YES please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Medical History:**

\_\_\_ Yes \_\_\_ No Were there complications with pregnancy, delivery, or immediately after birth? Was there prenatal drug, alcohol, or toxic exposure? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Was the child home from the hospital in a normal time frame? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Did he/she have a good APGAR score? Average score 7-10 \_\_\_\_\_

Who is your child's primary care physician? \_\_\_\_\_

Allergies to medications? \_\_\_ Yes \_\_\_ No

If Yes please list: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Immunizations up to date

What are your child's current non-psychiatric medications and doses? (including vitamins, herbs, etc) \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child ever experienced a head injury, loss of consciousness, or seizure? \_\_\_\_\_

Have you recently worried that your child may have problems with:

\_\_\_ Yes \_\_\_ No **Heart**      \_\_\_ Yes \_\_\_ No **Digestion**

\_\_\_ Yes \_\_\_ No **Lungs**      \_\_\_ Yes \_\_\_ No **Blood/infections**

(for office use only)

\_\_\_ Yes \_\_\_ No **Kidneys**      \_\_\_ Yes \_\_\_ No **Hormones**

\_\_\_ Yes \_\_\_ No **Neurological** \_\_\_ Yes \_\_\_ No **Other**

\_\_\_ Yes \_\_\_ No Any chronic medical problems? \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Yes \_\_\_ No Serious injuries? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Medical hospitalizations? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Surgeries? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Chronic pain? (headaches, stomachaches,  
chest

pain) \_\_\_\_\_

What time does your child go to bed? \_\_\_\_\_

What time does your child fall asleep?  
\_\_\_\_\_

How many hours of sleep within 24 hours on average does your  
child get? \_\_\_\_\_

Does your child nap during the day? Yes      No (circle)

Is your child tired during the day? Yes      No (circle)

### **Social History:**

\_\_\_ Yes \_\_\_ No Is your child your biological child? (If no, what age  
was he/she adopted? Is there contact with the biological  
parent(s)? ) \_\_\_\_\_

Where was your child born? \_\_\_\_\_  
And raised? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child moved a number of times?  
If yes, please list the age and location \_\_\_\_\_  
\_\_\_\_\_

(for office use only)

(for office use only)

Parents: (including Step-Mother and Step-Father, if applicable)

**Name**      **Occupation**    **Hrs/Wk**      **Relationship with Child**

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Please list the other siblings and other members of the household

**Name**                      **Age**      **Lives at Home?**      **Relation to Child**

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\_\_\_ Yes \_\_\_ No Are you struggling with your marital relationship or parenting? \_\_\_\_\_

If separated or divorced please describe the current custody and visitation arrangements: \_\_\_\_\_

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Are there any custody issues: \_\_\_ Yes \_\_\_ No

If YES please explain: \_\_\_\_\_

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**School:**

Where does your child attend school? \_\_\_\_\_

In what grade level? \_\_\_\_\_

What are his/her typical grades? \_\_\_\_\_

What are your child's academic strengths? \_\_\_\_\_

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Academic weaknesses? \_\_\_\_\_

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\_\_\_ Yes \_\_\_ No Has there been a change in your child's performance at school? If yes, please describe \_\_\_\_\_

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\_\_\_ Yes \_\_\_ No Has your child received IQ or Academic testing? If yes, what were the results? \_\_\_\_\_

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(for office use only)

Has your child participated in any of the following?

Check all that apply:

- Resource  504 Plan  
 Accelerated programs  Individual Education Plan (IEP)  
 Home-hospital programming

Has your child had problems with any of the following?

- Truancy  Fights  
 Absenteeism  Detention  
 Suspension

**CULTURE:**

Yes  No Do you have a religious preference in the household? If yes, what is that preference?

\_\_\_\_\_

Yes  No Has your child experienced any problems related to race, religion, or culture? If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**PEERS:**

Yes  No Does your child have quality relationships with other children? If no, please explain \_\_\_\_\_

\_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ABUSE:**

Yes  No Has your child ever been the victim of abuse or neglect? If yes, what was the nature of the abuse? (Please circle all that apply.)

- |                     |           |         |
|---------------------|-----------|---------|
| physical            | emotional | neglect |
| accidents           | disasters | sexual  |
| witnessing violence |           | other   |

Is there anything else you would like us to know about your child?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TEEN/YOUNG ADULT SECTION:**

Yes  No Do you have any concerns regarding your adolescent's friendships? (Please circle all that apply.)

- Too old      Too young      Truant      Gang-bangers
- Drug use    Alcohol use    Fringe      Violent
- Too many    Too Few      Gothic      Other

Yes  No Has your adolescent had a recent change in friendships? (If yes, what changes, if any are concerning to you?) \_\_\_\_\_

Yes  No Are you concerned that your adolescent is using (or has used) drugs or alcohol?

Yes  No Has your adolescent had use of weapons?

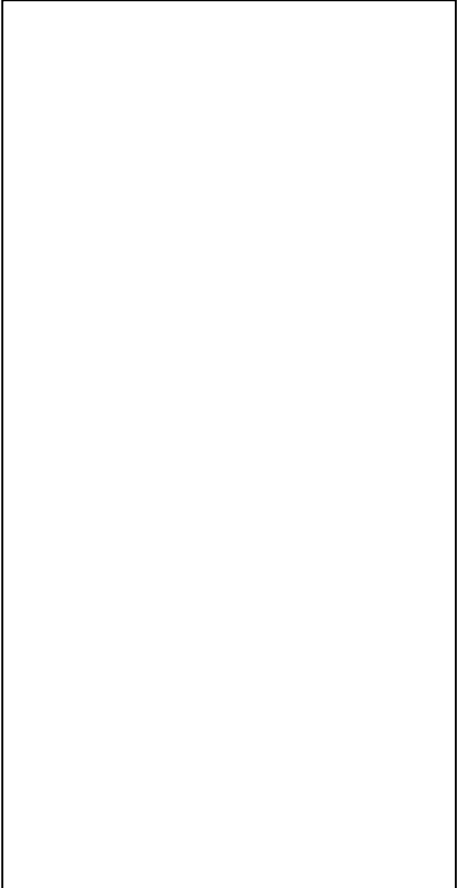
Yes  No Is your adolescent currently dating?

Yes  No Is your adolescent sexually active?

Yes  No Has your adolescent started working?

**Family History:**

Has anyone in your family had any of the problems or illnesses listed? (Blood related only)



Illness	Mom's side	Dad's side	Siblings	Other
Depression				
Bipolar				
Anxiety				
ADHD				
Schizophrenia				
Suicide Attempts				
Psychiatric Hospital				
Mental Retardation				
Autism or Aspergers				
Chromosomal Disorders				
Learning Disability				

Illness	Mom's side	Dad's side	Siblings	Other
Tic disorder				
Alcoholism				
Drug Abuse				
Jail or Prison				
Seizures				
Migraines				
Heart Problems				
Sudden Unexpected Death				
Diabetes				
Thyroid Disease				
Other Problems				

**Communication with Your Child's Doctor and Other Providers:**

At our clinic we try to work hand in hand with the primary care doctor and therapist of patients receiving services. This improves overall care provided for your child because we can learn more about your child's medical and therapeutic issues; and, your child's doctor and therapist will learn about our concerns regarding your child. We would like to ask your permission to make this contact.

If applicable, please list the contact information for your child's doctor.

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(name, address, and phone number)

If applicable, please list the contact information for your child's therapist.

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(name, address, and phone number)

Would you like a copy of your child's evaluation to be sent to another provider? If so, please list their names and office contact information.

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(name, address, and phone number)

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(name, address, and phone number)

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(name, address, and phone number)

**In order for us to release information to and/or contact those listed above, we will need you to sign a release of records following your child's evaluation. This abides with HIPAA regulations.**

**Yes  No Would you like records sent to your child's physician?**

**If yes, please visit our front desk and ask for a "*RECORDS RELEASE FORM*"**

**Thank you for taking the time to complete this important information.  
We look forward to meeting you and your child**