DR. MOLDOVER & ASSOCIATES

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Thank you for contacting our practice. Enclosed, you will find a number of forms which need to be filled out in advance of your upcoming appointment. These include a child development questionnaire; an agreement for psychological services; a financial agreement; and information of the management of confidential health information. Please take the time to review this paperwork and to complete your sections, and bring them with you when you come to the office.

The office is located on the second floor of 555 Washington Street in suite #5. Parking is on-street, or in a municipal lot across the street. Spaces are metered.

Please note that the office is on the second floor and the building has no elevator. If you have mobility concerns, please contact us ahead of time.

Included in this packet you will find a list of frequently asked questions. In addition, in the time leading up to your appointment you may have additional questions. Please feel free to contact us at 781 237 1735, or to email at info@drmoldover.com. Information is also available at www.drmoldover.com.

We look forward to working with you and your family.

Child Developmental History

A. Identifications

1. Child's full name: Birthdate:

Person(s) completing this form:

Today's date:

2. Parent One: Birthdate:

Home phone: Address:

Currently employed: ❑ No ❑ Yes, as:

Work phone:

Cell Phone:

Email:

Highest level of education:

3. Parent Two: Birthdate:

Home phone: Address:

Currently employed: ❑No ❑Yes, as:

Work phone:

Cell Phone:

Email:

Highest level of education:

4. Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married

Child's custodian/guardian is:

Please note: if parents are not married, complete attached child custody form.

5. Step-parent's name: Birthdate:

Home phone: Address:

Currently employed: ❑ No ❑ Yes, as:

Work phone:

6. Other family members (please include ages):

7. Is there any known family history of learning, developmental, neurological, or psychiatric disorder? (please specify):

B. Development

Please fill in any information you have on the areas listed below.

1. *Pregnancy and delivery*:

Prenatal medical illnesses and health care:

Was the child premature? ❑ No ❑ Yes. Weight and height at birth:

Any birth complications or problems?

2. *The first few months of life*:

Sleep patterns or problems:

Temperament & Personality as an infant (i.e., "easy"; "difficult to soothe", etc):

3. *Milestones: At what age did this child do each of these*?

Sat without support: _____

Crawled: _____

Walked without holding on: _____

Helped when being dressed (tied shoelaces; buttoned buttons; ate with a fork)

Stayed dry all day: _____ Stayed dry all night: _____

Age when child said first word understandable to a stranger: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties?

C. Health

List all *childhood illnesses, hospitalizations, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions*.

Condition	Age	Treated by whom?

Name of Primary Care Clinician (i.e., pediatrician):

Is the child currently prescribed any medications? (if so, please list name, dosage, and prescribing clinician):

D. Residences

Dates	
From To	Location

E. Schools

School (name, district, address, phone) Grade /Age

May I call and discuss your child with the current teacher? ❑ Yes ❑ No
If so, please note name and telephone number:

F. What are your child's strengths? Does he/she have any special skills or talents?

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.:

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

Child Custody Declaration

To be completed in instances in which parents are divorced, separated, or never married; or in which care is being sought for a foster child.

I hereby attest that I am the legal guardian of the child _____ (date of birth_____), and am thereby empowered to make all decisions pertaining to this child's health and educational needs, including the provision of psychological and neuropsychological services. In addition, I attest that no court order or custodial agreement limits my powers in this regard or requires additional consent from another party.

Name (printed) Date

Signature

In the space below, please provide the name, address, and telephone number of parents/guardians residing elsewhere:

Consent and Agreement for Psychological Testing and Evaluation

I, _____, agree to allow the psychologist named below and those assisting him/her to perform an evaluation, including neuropsychological, psychological, and educational testing as well as report preparation and consultation with other members of the clinical team for the purpose of coordinating care.

In addition, I wish to authorize the following:

❑ Consultation with school personnel
❑ Consultation with lawyers /advocates
❑ Other (describe):

_____

This agreement concerns ❑ myself or ❑ _____

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, and any other activities to support these services. If I have questions or concerns about this assessment, the evaluator agrees to be available to discuss these after completion of the testing and interviews.

Signature of client (or parent/guardian) Date

Signature of psychologist Date

Notice of Privacy Practices

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of a full, legally required notice of privacy practices, which is available upon request.

How we use and disclose your protected health information with your consent
We will use the information we collect mainly to provide you/your child with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

At times professionals outside of our practice may access information for the purpose of business/administration functions. Examples include accountants and book keepers who access our records. These individuals will have signed contracts with our office requiring that they keep any information that they access confidential.

Disclosing your health information without your consent
There are some times when the laws require us to use or share your information. For example:
1. When there is a serious threat to your/your child's or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are mandated to report child abuse or neglect or elder abuse or neglect.
3. When we are required to do so by lawsuits and other legal or court proceedings.
4. If a law enforcement official requires us to do so.
5. For workers' compensation and similar benefit programs.
6. When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the HIPAA Privacy Rule and the Commonwealth of Massachusett's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Your rights regarding your health information
1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work,

to schedule or cancel an appointment.
2. You can ask us to limit what we tell people involved in your care or the payment for your/your child's care, such as family members and friends.
3. You have the right to look at the health information we have about you/your child, such as your medical and billing records. You can get a copy of these records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing. You must also tell us the reasons you want to make the changes.
5. You have a right to restrict disclosures when you have paid for your care out-of-pocket (i.e., you have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services).
6. You have the right to a copy of this notice.
7. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact us directly at 781 237 1735.

You have a right to be notified if there is a breach of your unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

1. When the Practice becomes aware of or suspects a security breach the practice will conduct a Risk Assessment. The Practice will keep a written record of that Risk Assessment.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach within 60 days of discovery.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

The effective date of this notice is September 23, 2003.

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, when we use the words "you" and "your" below, this can mean you or your child. When we examine, test, diagnose, treat,

or refer you/your child, we will be collecting what the law calls "protected health information" (PHI). We need to use this information in our office to decide on what treatment is best for you/your child. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you/your child. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing.

If you do not sign this form agreeing to our privacy practices, we cannot treat you/your child. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 781 237 1735.

Please note: if you ask us to consult with other caregivers or with educators regarding your child, this request will release us to share information pertinent to the consultation.

Electronic communication: at times, you may wish to communicate with this office via email. Please note that this is not necessarily a secure means of communication. If you do NOT wish for us to use email to contact you please initial here and bring this to our attention:_____

Signature of client or his or her personal representative Date

Printed name of client or personal representative Relationship to client

_____

Signature of authorized representative of this office or practice

Financial Policies and Statement

A developmental neuropsychological evaluation consists of both clinical and educational components. Clinical components include neuropsychological assessment of neurologically based psychological functions such as memory and language. Educational components include assessment of academic skills using standardized tests, review of educational records, consultation with the teacher and school, and development and discussion of educational recommendations.

Health insurers may provide coverage for clinical evaluation, but as a matter of policy do not cover educational services. Therefore, the clinical aspects of the evaluation may be covered by your insurer; the educational portion will not be covered, however, and is your responsibility.

If we are providers for your insurance we will accept payment from the health insurer as payment in full for covered services rendered. However, in some cases health insurers deem part or all of the clinical portion of the evaluation to be not medically necessary. Should this be the case you will be responsible for services which are deemed not medically necessary..

Should you wish to proceed with service prior to payment being made in full we ask that you guarantee any subsequent costs for services with a credit card (please see attached).

We realize that insurance coverage is a confusing topic. Please refer to the attached FAQ's regarding insurance and costs for more information.

Your signature below indicates that you understand and consent to these policies.

Name (printed) Date

Name (signature)

(for office purposes)

Quoted out-of-pocket cost of evaluation:

Date of quote:

Signature of responsible party:

Signature of staff:

Insurance Information

Name of plan (e.g., Blue Cross/Blue Shield):

Name of subscriber (if not the patient):

Policy #:

Location of plan (i.e., state):

I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the psychologist above. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above

Date

_____

Printed name

Please read and complete the below securitization of evaluation costs:

I understand and agree that services which I am initiating at the present time may entail costs not covered by my health insurance, and that these costs will be my responsibility upon completion of the service.

I authorize charge to the credit card below in the amount of the services provided at my request, unless payment is provided in another form.

I understand that no charge will be made to this card until I have received notification of the outstanding balance and have been provided with thirty days to make payment through an alternate form.

Credit card type (NOTE: we do not accept AmEx):_____

CREDIT CARD #:_____

SECURITY CODE (on back of card): _____

EXPIRATION: _____

NAME ON CARD:_____

Signature:_____ Date:_____