Hunterdon Health

The Child Development Center
190 Rt. 31 N. Suite 500
Flemington, NJ 08822
(908)788-6396

The Child Development Center
Developmental Pediatric Associates

PROCEDURE FOR A NEURODEVELOPMENTAL EVALUATION

In order to prepare for your requested appointment, we have enclosed our history form, along with other forms that are necessary for the appointment. All forms need to be completed and returned to our office prior to scheduling an appointment.

Please use one of the following methods to return your child's history intake form.

- Hunterdon Health Developmental Pediatric Associates, 190 Route 31, Suite 500, Flemington, N.J. 08822
- Emailed to: Kristen Griffin - kgriffin@hhsnj.org.

Please also include copies of the following if appropriate:

- Child Study Team evaluations which have been completed within the last three years, along with a current IEP if applicable.
- Early Intervention records (Battelle testing and IFSP) if your child is currently receiving EI services.
- Medical Specialist reports.

After processing your completed paperwork we will call you to schedule an appointment. **The review process could take up to 6 weeks to complete.** Developmental Pediatric Associates currently has a **6-9 month waiting period** for **appointments.**

Please be aware that the doctor would like both parents to be present for consultation, along with their child. Due to the complexity and length of the evaluation, it is essential that you make child care arrangements for siblings since we are not staffed to provide childcare. The evaluation is approximately 1 ¾ hours in duration. As part of the evaluation, a brief assessment and vital signs will be conducted on your child in your presence.

On the day of appointment we ask that you arrive at our office at least 10 minutes prior to your scheduled appointment in order to register your child for services.

If you have any questions please feel free to contact the office at (908) 788-6650 prompt 3.

We look forward to meeting you and your child.

IMPORTANT INSURANCE INFORMATION

PLEASE NOTE: *Without correct insurance information, Hunterdon Health will be unal to submit to your insurance carrier and you will be held responsible for payment.*

INSURANCE INFORMATION: (*all information will be kept confidential*)

Insurance Company: _____ Plan Type: PPO HMO POS Other

Claims Address: _____

ID#: _____ Group #: _____ Referrals Needed: Y/N

Insurance Phone # (Member Service/Customer Service): _____

Primary Insurance Information:

Policy Holder's Name: _____ P.H.'s Date of Birth: _____

P.H.'s social security number: _____

Policy Holder's Place of Employment _____

Employer's Address: _____

Occupation: _____ Employed FT PT Retired Unemployed

Relation to patient: _____ Is policy holder Guarantor for patient? Yes No

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Secondary Insurance Information if applicable:

Policy Holder's Name: _____ P.H.'s Date of Birth: _____

P.H.'s social security number: _____

Policy Holder's Place of Employment _____

Employer's Address: _____

Occupation: _____ Employed FT PT Retired Unemployed

Relation to patient: _____ Is policy holder Guarantor for patient? Yes No

THE CHILD DEVELOPMENT CENTER

○ DEVELOPMENTAL PEDIATRICIAN ○ PHYSICAL THERAPY

○ OCCUPATIONAL THERAPY ○ CHILD PSYCHOLOGY

CHILD HISTORY INFORMATION

Today's Date: _____ *(please complete with BLACK/BLUE ink, do NOT use pencil)*

Patient's Name: _____ □ Male □ Female □ Preferred _____

Address: _____ **Birth Date:** _____

_____

Town State & Zip

Person answering questions:

Name: _____ Relationship to this child: _____

School: _____ **Teacher:** _____

Current Grade: _____ □ **IEP** □ **504 plan** □ **classification** _____

Phone: _____ **Case manager:** _____

MEDICAL CARE:

Primary Care Physician: _____ (Please enter physician name not the practice name)

PCP Phone #: _____ PCP Fax #: _____

Street Address: _____ Town: _____ State: _____

REFERRAL INFORMATION: Who referred you to our services? _____

Does your child have a diagnosis? No Yes Identify: _____

Why are you seeking help for this child? ***(please be specific)*** : _____

_____

_____

FAMILY:

Parent #1 Name: _____ Birth Date: _____

Relationship to child: □ mother □ father □ biological □ step □ adoptive □ resource

Address (if different from child): _____

Cell phone #: _____ Additional phone #: _____

Employment: _____ Highest level of education: _____

Health: □ excellent □ good □ fair

Learning, Attention or Emotional problems or other pertinent information: _____

_____

Parent #2 Name: _____ Birth Date: _____

Relationship to child: □ mother □ father □ biological □ step □ adoptive □ resource

Address (if different from child): _____

Cell phone #: _____ Additional phone #: _____

Employment: _____ Highest level of education: _____

Health: □ excellent □ good □ fair

Learning, Attention or Emotional problems or other pertinent information: _____

_____

Parents are: □ **Married** □ **Separated** □ **Divorced** □ **Other:** explain _____

If parents are separated or divorced, who has primary custody of this child? _____

Is there a custody agreement? : Yes No In progress

What adult(s) does this child live with? _____ How long in current living situation: _____

Primary language spoken at home? _____ Secondary language(s) _____

SIBLINGS: *Please list all brothers and sisters, and any other person living with the family.*

Name	Age	Relationship to child	Living at home?	Learning Problems?	Emotional Problems?

Any other family members with a history of learning disorders, attention issues or emotional problems: (example: Maternal grandmother has been anxious for years.)

Name	Description

Mothers Prenatal History

Mother's Maiden Name: _____

Was the mother under a doctor's care? (please circle one) Yes No Unknown

Number of previous pregnancies/miscarriages: _____

Check any of the following complications that occurred during pregnancy

Difficulty in conception ____ Toxemia ____ High Blood Pressure ____

Anemia ____ Vaginal Bleeding ____ Emotional Problems ____

Other Illness (Describe): _____

Maternal Injury (Describe): _____

Hospitalization during pregnancy, reason: _____

X-Rays during pregnancy, what month? _____

Medications during Pregnancy: ***Please list any medications used by the mother during pregnancy***

Medication	Frequency

Alcohol usage prior to pregnancy (Frequency): _____

Alcohol usage during pregnancy (Frequency); _____

Cigarettes used during pregnancy (Frequency): _____

Drugs/substances used during pregnancy (Frequency): _____

CHILD'S BIRTH

At child's birth, what was the mother's age? _____ Father's age? _____

Where was your child born? (Hospital / State / Country)_____

Is your child a twin / multiple? No Yes: Fraternal Identical

Length of pregnancy. _____ weeks Birth weight: _____ lbs. _____ oz.

Length of stay in hospital: Mother_____ days Child _____ days

Check any of the following complications that occurred during birth.

_____ Forceps used _____ Breech birth _____ Labor induced _____ C-Section

_____ Other delivery complications: Describe _____

_____ Incubator: No Yes How long? _____

_____ Jaundiced: No Yes_____ Bilirubin lights: No Yes If yes, how long? _____

_____ Breathing problems: Describe _____

_____Was or is your child on any monitor? Please list: _____

Child's condition at birth: _____Apgar Score: _____

Mother's condition at birth: _____

Did/does your child have colic (please circle one) Yes No Duration? _____

Breast fed? No Yes Difficulty feeding? _____
Bottle fed? No Yes Difficulty feeding? _____

DEVELOPMENTAL HISTORY

At what age did your child do the following? *Please indicate age:*

Gross Motor Skills:

_____ Independently roll over _____ Sit alone _____Crawl _____Pull to stand _____Stand alone

_____ Walk alone _____Walk up stairs _____Walk down stairs _____Jump with 2 feet

Fine Motor Skills:

_____ Pointing _____ Pincer grasp _____ Button/Zipper/Snap _____ Tying Shoelaces

Language Skills:

_____ Spoke first word (*other than MaMa Da Da*) _____ Spoke 2-3 word phrases

Can a stranger understand your child's speech? (please circle one) No Yes Percentage _____%

Which hand does your child use for:

Writing, drawing, coloring:	Left	Right
Eating:	Left	Right
Throwing:	Left	Right

Does your child switch hands when writing? No Yes

Has your child had:

Difficulty learning to walk	No	Yes _____
Difficulty learning to ride a bike	No	Yes _____
Difficulty learning to skip	No	Yes _____
Difficulty learning to throw or catch	No	Yes _____
Difficulty with balance	No	Yes _____

Toilet Training:

When was your child toilet trained for urine? Daytime. _____ Nighttime _____ Not Trained _____
When was your child toilet trained for stool? Daytime. _____ Nighttime _____ Not Trained _____
Did bed-wetting occur after toilet training? No Yes If yes, until what age? _____
Any medical reasons _____

Does your child use any adaptive equipment? Please list _____

ADAPTIVE SKILLS: <u>To be completed only if your child is 4 years or older</u>
Please circle whether your child has the following skills

Dresses self	No	Yes	Bathes self	No	Yes
Helps with household chores	No	Yes	Knows how to ask for help	No	Yes

MEDICAL HISTORY (Please circle all that apply)

GASTROINTESTINAL: Excessive vomiting Frequent Diarrhea Constipation Chronic Abdominal Pain

MUSCULOSKELETAL: Muscle Pain Clumsy Walk Toe Walk Poor Posture Scoliosis
Broken bones Other Muscle or Bone Problems_____

RESPIRATORY: Frequent Colds Asthma Hay Fever

HEARING: Ear Infections Hearing Problems Ear Tubes Date of most recent Hearing Exam:_____

VISION: Vision Problems Wears Glasses Date of most recent Vision Exam _____

CARDIOVASCULAR: Shortness of Breath Dizziness with Exertion Limitations Due to Heart Condition Heart Murmur Anemia

NEUROLOGICAL: Seizures Chronic Headaches Encephalitis/Meningitis Verbal/Motor Tics Head Injury or Concussion Loss of Consciousness High Lead Levels

OTHER MEDICAL HISTORY:_____

ALLERGIES: _____

SKIN: Birthmarks Eczema Frequent rashes

IMMUNIZATION

Current – Yes/No If not, please explain reason _____

MEDICATIONS

Please list all LONG-TERM medications this child has ever been on:

AGE	MEDICATION	DOSAGE/STRENGTH	HOW LONG ON MEDICATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any CURRENT MEDICATIONS prescribed or OTC/supplements

MEDICATION	DOSAGE/STRENGTH	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ANY HOSPITALIZATIONS OR EMERGENCY ROOM VISITS

Year _____ Please circle: Hospital Stay or ER visit: Reason _____

Year _____ Please circle: Hospital Stay or ER visit: Reason _____

Year _____ Please circle: Hospital Stay or ER visit: Reason _____

PLEASE LIST ANY MEDICAL SPECIALIST THAT YOUR CHILD HAS SEEN IN THE PAST OR IS PRESENTLY SEEING

Specialist	Reason for seeing specialist	Last seen

PLEASE INDICATE ANY TESTING YOUR CHILD HAS HAD (Please circle all that apply)

Hearing MRI EEG CT Scan Lead Thyroid

Other Testing not listed _____

SOCIAL EMOTIONAL HISTORY

FRIENDSHIPS

Please indicate how your child relates to other children (including siblings)

Has problems relating to or playing with other children? No Yes

If yes, describe: _____

Fights frequently with playmates No Yes _____
Prefers playing with younger children No Yes _____
Prefers to play alone No Yes _____

Are there children in the neighborhood with whom this child could play? No Yes

What role does your child take in peer groups (leader, aggressor, etc.)? _____

RECREATION/INTERESTS

What activities does your child enjoy? *(sports, hobbies)* _____

_____

_____

Has your child's interest in participating in these activities declined recently? No Yes

BEHAVIORAL HISTORY

Does your child experience any of the following problems? (now or in past) If yes, briefly describe:

Eating	No	Yes	_____
Sleep: getting to sleep	No	Yes	_____
& staying asleep	No	Yes	_____
Eye contact	No	Yes	_____
Sensitivity noise/touch/smells	No	Yes	_____
Separating from parents	No	Yes	_____
Temper tantrums	No	Yes	_____
Activity level	No	Yes	_____
Accident prone	No	Yes	_____
Short attention span	No	Yes	_____
Lacks self control	No	Yes	_____
Bangs head	No	Yes	_____
Seems anxious	No	Yes	_____
Tics/Twitches	No	Yes	_____
Overreacts with problems	No	Yes	_____
Requires lots of parental attention	No	Yes	_____
Toe walks	No	Yes	_____
Mood swings	No	Yes	_____

Is your child sad more often than he/she is happy? No Yes
If yes, describe _____

What makes your child angry? _____

Has your child ever experienced any parental separations, divorces, or deaths? No Yes
If yes, when? _____ How old was your child at the time? _____

What do you enjoy most about your child? _____

_____

What do you find most difficult about raising your child? _____

_____

EDUCATIONAL HISTORY

Early Intervention Program (EIP)
Was your child involved in EIP? No Yes Still Active? No Yes
County/State: _____ Services received: _____
Developmental Intervention Frequency: _____ Occupational Therapy: _____ Frequency: _____
Physical Therapy Frequency: _____ Speech Therapy: _____ Frequency: _____

Childcare/Preschool
Does your child currently attend childcare or preschool? No Yes Where? _____
Days per week: _____ Amount of time/day: _____
Any problems in daycare/childcare? No If yes, describe: _____
Does your child have an IEP? No or Yes If yes, what services do they receive: _____

Schools attended

Elementary Schools Attended	Concerns or problem in school

Middle Schools Attended	Concerns or problem in school

High Schools Attended	Concerns or problem in school

Is your child classified, does she / he receive special services: Yes No If yes: IEP or 504 Plan
Classification: _____

A self-contained special class? No Yes Class type: _____

Resource room: No Yes For what subjects: _____

Total hours per day: _____ Totally mainstreamed? No Yes

Does your child receive OT / PT / Speech Therapy / ABA / Paraprofessionals in school (1:1 aide)

Please keep this form for your records

Explanation of Prolonged Codes

CPT codes 99417 and G2212

You may see these codes on your EOB

These codes are used in conjunction with the following Office Visit codes:

99205 - New Patient

99215 - Established Patient

Prolonged codes are added automatically by the system based on the physician's stated amount of total time spent on your appointment which is noted at the end of the evaluation report and includes the following:

- Face to Face time spent at your appointment with the physician Chart review prior to appointment
- Scoring testing materials administered during the appointment Review of any additional paperwork brought to appointment ie; CST evaluations, IEPs, medical reports or records
- Dictating and editing your report
- Phone calls to case managers or other medical professionals if applicable

Hunterdon Healthcare

Child Development Center

Developmental Pediatric Associates

Insurance Obligation

Please be advised we bill as a Specialist Office.

If your insurance plan is referral based, the referral should be made out to Hunterdon Medical Center Developmental Pediatric Associates - NPI #1295371441, Tax ID # 221537688.

Physician NPI if needed:

Dr. Audrey Mars - NPI 1295808236

Dr. Michael Vergara - NPI 1053433961

Kristen Rozano, CPNP-PC - NPI 1619350733

It is your responsibility to contact your insurance provider to confirm your benefit. You may be subject to a copay, deductible and or co-insurance payment. You are responsible for any costs not covered by your insurance plan.

These are the billing codes we use:

New Patient CPT code - 99205

Established Patient CPT code - 99215

Prolonged CPT code - 99417 or G2212 (used in combination with the above two codes)

Thank you

Hunterdon Healthcare

Child Development Center

Developmental Pediatric Associates

24 Business Hour Appointment Cancellation Policy

Developmental Pediatric Associates has a 24 hour cancellation/rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than a 24 business hour notice, you will be charged the following fee:

$100.00

This fee will not be billed to or covered by your insurance company.

This policy is in place out of respect for our physicians and their patients. Cancellations with less than a 24 business hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent another patient from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Developmental Pediatric Associates as described above.

_____ _____

Printed Name Signature

_____

Date

Hunterdon Health

Authorization for Disclosure of Protected Health Information

I, _____ hereby authorize HMC - Developmental Pediatric Associates to disclose information from the records of:

_____ ____/____/____
Patient's Name Date of Birth

_____
Patient's Address City State Zip Code

Circle one in each box: (Released To) / Released From

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Please fill in Primary care Physician info here

Circle one in each box: Released To (Released From)

Name: Developmental Pediatric Associates

Address: 190 Route 31, Suite 500

City: Flemington State: NJ Zip Code: 08822 Phone: 908-788-6650

Purpose for request:

_____ For personal use only (not transferring from practice)
_____ Transferring care to another local practice due to _____
_____ Relocation out of area
__X__ Other
_____ Insurance change-related (please indicate carrier) _____

The following information is to be released: (Please check one)

__X__ **Entire Medical Record.** Records specifically protected under State and Federal Confidentiality Statues. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and Federal law and prohibits any further disclosure without written consent of the persons to whom it pertains or otherwise provided by law.

_____ **Only specific portions of the medical record.** Itemize portions of record and time period of records to be released and indicate specific records that may not be released.

Date Range: from ____/____/____ to: ____/____/____

Specific records **NOT** to be released: _____

THIS AUTHORIZATION WILL REMAIN IN EFFECT: (Check One):

□ Until the following event occurs: _____ □ 180 Days □ OTHER: _____

Patient's Name:_____/ DOB_____

I understand that once Hunterdon Health discloses my health information to the recipient, Hunterdon Health cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Hunterdon Health may, directly or indirectly, receive remuneration from a third part in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Hunterdon Health; except, however, if my treatment in the Hunterdon Health is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Hunterdon Health may refuse to treat me if I do not sign this Authorization.

If my treatment is related to my participation in a research study, I understand that treatment may be refused if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Hunterdon Health Privacy Officer at the address listed below. The revocation will be effective immediately upon Hunterdon Health receipt of my written notice, except that the revocation will not have any effect on any action taken by Hunterdon Health in reliance on this Authorization before it received my written notice of revocation.

I may contact Hunterdon Health by mail at:

Hunterdon Health
Health Information Management Services
2100 Wescott Drive
Flemington, N.J. 08822
Phone: 908-788-6380

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Hunterdon Health to use or disclose my heath information in the manner described above.

X_____ _____

Signature of Patient/Parent/Legal Guardian **Date**

_____

Relationship to Patient

Notice to Recipient of Information

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information as indicated by their initials under Part 3 of this form the following Notice applies to the information you have received pursuant to this information. This information has been disclosed to you from records protected by Federal confidentiallty rules C.F.R. Part @. The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.