

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 3/4 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 unable 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

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

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: To be completed only if your child is 4 years or older

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

Please keep this form for your records

Hunterdon Healthcare Child Development Center
Developmental Pediatric Associates
Insurance Obligation

Please be advised that 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.

Here are our Physician NPI numbers if needed:

Dr. Audrey Mars - NPI 1295808236

Dr. Michael Vergara - NPI 1053433961

Kristen Rozano, APN - 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

February 2026

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 _____