THERAPY QUESTIONNAIRE

Date

Child's Name | Date of Birth | Age

Street address, City, ST, ZIP Code

Mother's Name and cell | Father's Name and cell

Person completing forms | Email

Parent's marital status | Legal guardian

Siblings and other household members

Name	Relationship	Age	Problems	Diagnosis

Emergency contact information

Name and relationship | Phone #

Name of pharmacy | Phone of pharmacy

Referred by | How did you find us?

Past medical/surgical history _____

Hosipalizations_____

Current Diagnosis

- ☐ Autism Spectrum Disorder
- ☐ ADHD
- ☐ sensory processing disorder
- ☐ Anxiety
- ☐ Asperger's Syndrome
- ☐ ODD
- ☐ depression
- ☐ Other (please specify below)
- ☐ PDD-NOS
- ☐ speech delay
- ☐ OCD

Current Physicians and Addresses _____

_____

_____

Drug, food, environmental Allergies _____

_____

Current Medications, vitamins, herbs or supplements

Name	Dose	Date started	Comments/observations

Past Medications, vitamins, herbs or supplements

Name	Dose	Date started/stopped	Reason/observations

Family medical history please include developmental, medical, psychological

Relationship	Age	Medical History

Current School Placement

Name of School/address _____ IEP or 504 Classification _____

Type of class setting _____ CST Evaluation Yes No In Out of District

Did your child ever have to repeat a grade Yes No

Current School Therapies

☐ PT ☐ OT ☐ Speech ☐ ABA ☐ Behavioral therapy ☐ Social skills

☐ Other _____

How many times a week _____

_____

Private Therapies

☐ PT ☐ OT ☐ Speech ☐ ABA ☐ Behavioral therapy ☐ Social skills

☐ Other _____

How many times a week _____

_____

Type(s) of service desired: { } Child therapy { } Adolescent therapy { } Family therapy

Child's main problem/major reason for seeking help at this time: _____

How long has your child had these problems, symptoms, or issues?_____

Has your child had treatment for these issues in the past? { } Yes { } No
If Yes, was the outcome helpful? { } Yes { } No

Has your child had inpatient mental health treatment? { } Yes { } No
Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:

Describe any other behavioral or emotional problems your child is having: _____

Describe the impact of your child's problems on the family
Describe your child's strengths and unique qualities: _____

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? { } Yes { } No (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses If yes please describe:_____

Forms of discipline used in the home:
{ } Time out { } Loss of privileges { } Grounding { } Rewards/incentives { } Extra chores
Other_____

Does this child have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No
If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child/family:_____

Is there legal action pending related to accusations of abuse? { } Yes { } No

If yes, describe briefly: _____

BEHAVIOR CHECKLIST

Please check any of the following behaviors that concern you:

Behavior	Past	Current	Behavior	Past	Current
Crying, sadness, depression			Temper outbursts		
Loss of enjoyment of usual activities			Irritability, anger		
Bedtime fears, won't sleep			Argues a lot		
Has threatened/attempted suicide			Disobedience		
Worries more than others			Does things that annoy others		
Panics			Unusual fears or phobias		
Repeats unnecessary act over and over			Anxious, nervous		
Has rituals, habits, superstitions			Is overly concerned about things		
Eats very little/fasts to lose weight			Twitches or unusual movements		
Sleepwalking			Gorges or binge eats		
Withdrawn			Blames others for own mistakes		
Nightmares, night terrors			Easily annoyed by others		
Low self-esteem			Swears or uses obscene language		
Wakes up very early, unable to go back to sleep			Wanting to run away		
Tiredness, fatigue			Sneaks out at night		
Restless sleep, wakes frequently			Injures self		
Trouble going to sleep			Stealing		
Sleeps too much			Lying		
Poor appetite			Hurts animals		
Under or overweight			Destroys property		
Over-activity			Hurts people		
Frequently acts without thinking			Drug use		
Doesn't finish things			Alcohol use		
Disruptive			Cigarette use		
Short attention span			Sexual problems		

Daydreams, fantasizes			Problems with authority		
Easily distracted			Problems with the law		
Hallucinations			Low motivation		
Bedwetting/daytime wetting			Vomits intentionally		
Disorientation			Soiling (pooping) in pants		

Relationship Development

Check each item that describes your child:

Behavior	**Past**	**Current**	**Behavior**	**Past**	**Current**
Prefers to be alone			Bullied		
Is alone a lot, but dislikes this and feels lonely			Teased by others		
Is shy			Oversensitive		
Has Friends			Bullies others		
Keeps Friends			Demanding or Bossy		
Plays with "problem kids			Fights with others		
Plays with younger children			Teases others children		
Plays with younger children			Poor Relationship with teachers		

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child:_____

_____

_____

_____

2006 Highway 71, suite 4 Spring Lake Heights, NJ 07762
Phone: 732-919-1335
Email: info@cwdcenter.com

Welcome and thank you for choosing the Children's Wellness & Developmental Center, LLC (hereinafter "The Center"). In order for us to provide you the best care possible in the timeliest way possible, please read carefully and initial your understanding and willingness to abide by the following practice polices. Feel free at any time to ask questions if there is something you do not fully understand. After you have read and initialed the policy and bill of rights, please sign acknowledging the understanding of what you have read and that the Children's Wellness & Developmental Center, LLC have provided you with this important information.

Appointments:

_____New Patients: We ask that you be on time for your appointments and please allow ample time for your visit. Please download and complete the New Patient packet and Notice of Privacy Practices. If applicable bring copies of any school reports, consultations, and or medical records, you may have for your child. Please bring any prescriptions or supplements your child may be taking.

_____ Follow up Patients: Please bring any prescriptions or supplements your child may be taking and school reports, evaluations or updated medical records.

_____Cancellation policy is as follows: **If you need to reschedule your appointment it must be done by phone or text. No later than 24 hours for follow ups and 72 hours for new patients, before your scheduled appointment time.** We are mindful of your busy schedules and you must keep in mind that if you don't keep your appointment, that spot could have been given to another child who needed to be seen.

If you do not cancel your appointment in time or you do not show up for your appointment you will be charged your full session fee.

Appointments/Cancellation Policy

I understand I ***will be charged for sessions not cancelled at least 24 hours before my scheduled appointment*** and that ***cancellations are accepted by voicemail or text.*** I also understand that payment is due at the time of service.

Signature _____ Date _____

Signature _____ Date _____

Credit Card Payments

#_____

Exp. Date_____

CSC#_____

Billing zip code_____

Signature _____ Date _____

_____Follow up's to review blood work, testing, updated treatment plan, and or to discuss documentation that is needed to be completed, that is not during your regularly scheduled appointment will be billed as a follow up appointment.

_____Copies of reports, test results, laboratory results, specialty lab results, office visits, can be requested at the time of appointments or picked up in person. No results will be emailed, mailed or faxed.

_____ Patients must be seen once a year to continue at our practice.

Financial Policy:

_____The Center is a direct-pay service practice. Payment in full is due on the date of service. The Center does NOT accept insurance of any kind. The services that you receive at The Center, may or may not be covered under your out-of-network insurance benefits coverage. It is your responsibility to contact your insurance company directly, prior to your appointment, if you choose to submit any out-of-network benefits. Upon request, The Center will provide you with the necessary form and an itemized invoice to submit to your insurance company. Said documents will be provided to you at the conclusion of your visit so that you may submit them to your insurance company if you chose to do so.

_____ Payments can be made by check, cash or credit cards at the time of services rendered. There is a 2.75 % service charge added to all credit card transactions and a 3.5% service charge for all credit card transactions taken over the phone.

_____All balances must be paid at the time of your appointment. This includes billed charges such as those for no shows, late cancellations, or documentation that was requested to be completed.

_____A $25 fee will be charged for all returned checks

Paperwork:

_____ There will be a $50 fee assessed for any paperwork required from The Center outside of visit documentation, including but not limited to letters, and any other documentation requiring any portion of our time to fill out.

Communication:

_____ We are available to our patients by email and telephone for basic inquiries requiring short responses. Our policy is to return phone or email messages within 48 hours. Messages received between Friday 2pm and Monday 11am will be returned on Monday/Tuesday during the day. **Phone calls NOT initiated by the staff requiring more than 5-10 minutes, will be billed as a follow up appointment.**

Rights:

_____The Children's Wellness and Developmental Center is a multi-disciplinary practice that offers a variety of services for its patients and families. However, if you choose a provider that is outside of The Center's practice, and you give The Center authorization, The Center will work with and communicate with the provider of your choice, in order to treat and to service you.

_____I have assisted The Center in developing my treatment and service plan and as such, I am in agreement with such plan. All individuals that I desired to include in the planning process were invited to participate. I had the ability to choose the services in my Plan. I had the ability to choose the providers of my services based upon the available providers. I am aware of my rights and responsibilities as a participant in this service plan. The Center may share my service plan with all providers in order to implement my treatment. Additionally, I authorize all service providers at The Center to collaborate in order to appropriately service and treat me.

The Center may not share my service plan with: (name listed - only if applicable).

_____

_____

Authorization to be contacted via voicemail, email or text mgs:

_____I authorize the Children's Wellness & Developmental Center, to contact me through voicemail, email or text message. I understand that in doing so, my protected health information may be viewed by individuals I did not intend. I understand that I may revoke this request, in writing, at any time.

Notice of Privacy Practice Acknowledgment:

_____I understand that, under the Health and Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received and read the Notice of Privacy Practices. I understand that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Authorization to Disclose Protected Health Information:

_____I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" under HIPPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
Limitations of Discloser: Please describe below limitations you would like on the disclosure of your Protected Health Information and/or Financial Information

_____

_____

I understand that I may revoke this permission, in writing, at any time. Revoking permission, However, does not affect previous disclosures that were made with my consent.

_____I further understand that The Center is in possession of my personal information. This personal information may include (but is not limited to) my name, my address, my contact information, my emergency contact designee / information, as well as other personal and private information. The Center is also in possession of protected information, known under the law as "Protected Health Information (PHI)." Said information is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

By and through my signature below, I am in agreement with the above provisions and the possible release of the aforementioned information, including PHI, in a manner compliant with HIPAA and other applicable laws.

By completing and signing this form, I, or my legal representative, agree to allow The Center (and its subsidiaries, affiliates, employees, agents and subcontractors) to share my personal information, including PHI, in a manner compliant with the law.

"I have fully read, initialed, understand and agree with the above stated policy.
The staff at the Children's Wellness & Developmental Center have verbally explained these policies to me and have answered any questions or concerns that I have. By signing I understand and agree to the policies at the Children's Wellness & Developmental Center."

Patient or Legal Guardian (print name & relationship) _____

Patient's Name_____

Signature_____Date_____

Informed Consent for with Treatment Children's Wellness & Developmental Center, LLC

I, _____, (Patient/Guardian) do voluntary consent to initiate Evaluative / Diagnostic / Therapeutic procedures and Medical Treatment, to clarify issues pertinent to the health, development or adjustment of the patient by the provider/providers at The Center, as is necessary.

I am aware of and understand that the practice of healthcare is not an exact science, and I acknowledge that no guarantees have been made to me as to treatment, evaluation, and/or outcome.
I am aware that I am an active participant in this endeavor, and that I share the responsibility for treatment by providing all accurate information about my history and current health/behavioral status.

My signature below indicates my informed consent. I also understand that I have the right to revoke this consent in writing and terminate services with provider/providers at The Center at any time.

Patient or Legal Guardian (print name & relationship) _____

Patient's Name_____

Signature_____Date_____

Consent for Child Treatment

I am the parent/legal guardian of _____ with full legal authority to consent to treatment. I give permission for _____ to provide treatment for this child, which may include assessment, advocacy, referral and mental health counseling.

Patient or Legal Guardian (print name & relationship) _____

Patient's Name_____

Signature_____Date_____

Please list any adults who are authorized to drop off or pick up your child from his/her therapy session in the event you or another legal guardian are unavailable:

_____Relationship to child _____

_____Relationship to child _____

_____Relationship to child _____

Please note: An authorized adult must remain in the waiting room at all times when a minor is in a therapy session. I authorize the above named person(s) to drop off or pick up my child from his/her therapy session. I agree that I or any person named by me (listed above) will not leave the premises and will remain in the waiting room for the duration of my child's therapy session.

Patient or Legal Guardian (print name & relationship) _____

Patient's Name_____

Signature_____Date_____

PATIENT BILL OF RIGHTS

Please read the following carefully and feel free at any time to ask questions if there is something you do not fully understand. After you have read this list of rights, please sign below acknowledging that the Children's Wellness & Developmental Center, LLC have provided you with this important information

It is our **LEGAL DUTY** and **OBLIGATION** to-

-To treat you with consideration and respect in a safe setting free from all forms of abuse and harassment. Your privacy will be protected.
-To keep all communications and records about your care confidential. In general, you have the right to see all the information in your health records.
-To provide clearly written and spoken information in words you can understand.
-To provide all the information you need to make an informed decision about your care including information about your options, risks and benefits, possible outcomes, possible side effects, who is providing your care and all possible costs.
-To respect your decision to refuse care. To allow you to leave the office even if the physician advises against it.
-To provide you with the freedom of restraints and seclusion of any form that is not medically necessary.
-To provide you with all available information about possible research participation and obtain your informed consent.
-To give you the opportunity to examine and receive an explanation of your bill regardless of source of payment.
- To allow you to express a concern or complaint and receive a prompt response.

You also have the right to file a formal grievance if you are not satisfied with the resolution of your complaint.

I have read and fully understand this Patient Bill of Rights.

Patient or Legal Guardian (print name & relationship) _____

Patient's Name_____

Signature_____Date_____