

Insights

Colorado Assessment and Therapy, PC

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Denver, CO 80203
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Child/Adolescent Diagnostic Assessment-Intake Information

Patient's Full Name: _____

Date of Birth: _____ Age: _____ Gender: ___ M ___ F

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Email: _____

Insurance Information:

Insurance Carrier: _____ Phone: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

Member ID#: _____ Group#: _____

Primary Insured

(if different from patient)

Full Name: _____ Gender/Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS#: _____

Referral Source

Name: _____ Phone: _____

Authorizations

I understand that it is my responsibility to know my insurance benefits including information regarding my deductible, co-insurance, and copays. I hereby authorize payment directly to Insights, PC and hereby authorize Insights, PC to release any information required in the processing of my insurance claims.

Signature (Insured Person): _____ Date: _____

Child's Challenges

Social (cooperative play, interest in peers, friendships, etc.): _____

Communication (small talk, reading social cues, asking for help, etc.): _____

Behavioral (tantrums, aggression, etc.): _____

Self-Care (hygiene, dressing, chores, etc.): _____

Motor (fine, gross, low tone, planning, etc.): _____

Routines/Transitions (tolerating changes, switching between activities, etc.): _____

Executive Functioning: (planning, focus, organization, etc.): _____

Safety: (self-injurious behaviors, running away, etc.): _____

Child's Strengths

Learning (style, subject strengths, detail oriented, etc.): _____

Personality (curious, sensitive, funny, outgoing, etc.): _____

Social (talkative, friendly, empathic, etc.): _____

Interests/Talents (art, building, sports, etc.): _____

Other: _____

Reason for Referral
(why are you seeking help for your child?)

Reason 1: _____

Reason 2: _____

Reason 3: _____

Parent Information

Parent #1 Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Email: _____

Occupation: _____ Work Phone: _____

Parent #2 Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Occupation: _____ Work Phone: _____

Parents are: In a relationship Married Separated Divorced

Custody arrangements if divorced or separated: _____

If Divorced or separated, who has custody of this child? _____

Current living arrangements are as follows: _____

List all others living in the household with your child

| Name | Age | Gender | Relationship to child |
|------|-----|--------|-----------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Prenatal History

Length of pregnancy (weeks): _____ Length of Labor (hours): _____ Weight at birth: _____

Complications during Pregnancy: _____

Complications during labor: _____

Substances used during pregnancy:

___ Cigarettes: If so, how many per day _____ week _____

___ Alcohol: If so, how many drinks per day _____ week _____

___ Drugs: If so, please describe type(s) of drug and frequency during pregnancy:

Medical problems during the 1st year of your child's life?: _____

Developmental Milestones

Please list approximate age at which milestones were met:

Age of 1st words: _____ Examples of 1st words: _____

Age of Phrase speech: _____ Age Walked: _____ Toileting: _____

If your child experienced a regression in any of the above skills, please explain below:

Educational Information

Current School: _____ Grade: _____

Individualized Education Plan (IEP): Yes ___ No ___ 504 Plan: Yes ___ No ___

Date Started: _____ Date terminated: _____

Reason for IEP/504 Plan: _____

Services received: Speech ___ OT ___ Academic ___ Mental Health ___ Other ___

Academic Concerns: _____

School Behavior Concerns: _____

Medical History

Please note all testing previously conducted, including testing, date, and results.

Head Injury: _____

Date(s): _____ Results: _____

Seizures: _____

Date(s): _____ Results: _____

Surgery: _____

Date(s): _____ Results: _____

Speech/Language: _____

Provider/Date(s): _____

Sensory/Motor: _____

Date(s): _____ Results: _____

Hearing: _____

Date(s): _____ Results: _____

Vision: _____

Date(s): _____ Results: _____

Genetic Testing: _____

Date(s): _____ Results: _____

Immunological: _____

Date(s): _____ Results: _____

Allergy: _____

Date(s): _____ Results: _____

Other: _____

Date(s): _____ Results: _____

Current Medications

Please list any medication or supplements (including medical marijuana) and reason for medication:

Medication 1: _____ Reason Prescribed: _____
 Medication 2: _____ Reason Prescribed: _____
 Medication 3: _____ Reason Prescribed: _____
 Medication 4: _____ Reason Prescribed: _____

Additional Information

| | Does your child have a history of any of the following? If so, please explain: |
|-----------------------------|--|
| Speech issues | |
| Fine motor problems | |
| Gross motor problems | |
| Special diet | |
| Weight issues | |
| Food allergies | |
| Seasonal allergies | |
| Stomach Problems | |
| Many ear infections | |
| Dental problems | |
| Sensory seeking behaviors | |
| Sensory defensive behaviors | |
| Asthma | |
| Sleep disturbance | |
| Suicidal Behavior | |
| Depression | |
| Anxiety | |
| Aggression | |
| Hallucinations/psychosis | |
| Alcohol/Substance use | |
| Trauma | |

Previous Diagnosis: _____ Date Received: _____

Previous Diagnosis: _____ Date Received: _____

Previous Diagnosis: _____ Date Received: _____

**Please attach results/reports from previous evaluations*

Intervention History

Please list previous and/or current therapies that your child has or is participating in. This could include but is not limited to:

Applied Behavior Analysis (ABA)
Occupational therapy (OT)
Speech therapy
Physical therapy (PT)
Psychotherapy

Therapy 1 (please specify type of therapy): _____

Agency/Provider: _____

Frequency: _____ daily _____ weekly _____ bi-monthly _____ monthly _____ other

Date Started: _____ Date Completed: _____

Treatment goals: _____

Therapy 2 (please specify type of therapy): _____

Agency/Provider: _____

Frequency: _____ daily _____ weekly _____ bi-monthly _____ monthly _____ other

Date Started: _____ Date Completed: _____

Treatment goals: _____

Therapy 3 (please specify type of therapy): _____

Agency/Provider: _____

Frequency: _____ daily _____ weekly _____ bi-monthly _____ monthly _____ other

Date Started: _____ Date Completed: _____

Treatment goals: _____

Therapy 4 (please specify type of therapy): _____

Agency/Provider: _____

Frequency: _____ daily _____ weekly _____ bi-monthly _____ monthly _____ other

Date Started: _____ Date Completed: _____

Treatment goals: _____

Insights

PATIENT NAME: _____

DATE: _____

CONSENT TO TREATMENT

The information on this page is made available so that you will be fully aware of some important matters concerning the psychologist-patient relationship and Insights policies. A “psychologist-patient” or “treatment” relationship does not exist until after an initial assessment is completed and we have decided to move ahead as evidenced by your signature on this form. It is important that we agree that we will be able to successfully work together to accomplish your goals. We will discuss this during the first visit and decide whether or not to proceed, and whether we need to continue the assessment for one or more subsequent visits.

CONFIDENTIALITY AND HIPAA

Generally speaking, the information provided by and to the patient during the assessment and any subsequent treatment, is legally confidential and cannot be released without the patient’s consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 and the Notice of Privacy Rights that can be provided to you in full upon your request as well as other exceptions to Colorado and Federal Law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception to psychologist-patient arises, if feasible, you will be informed accordingly.

Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later. When the client is a child, the records must be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

DIAGNOSTIC ASSESSMENT

Diagnostic Assessment is a process that requires involvement from the patient, family, and, at times, other caregivers, such as teachers or therapists. These services require face-to-face contact for interviewing and testing. They also include the psychologists’ time required for the reading of records, consultations with other professionals, scoring of tests, interpreting of results, report writing, and any activities to support these services.

INSURANCE

We will be glad to provide invoices to help in filing insurance claims. However, you will be responsible for the full fee at the time of service unless we make other arrangements. If you are insured by a carrier with whom we contract with part of your evaluation may be covered by insurance. In these cases, you are still responsible at the time of service for any co-payment, co-insurance, and deductible depending on your plan. Additionally, if your insurance carrier will be reimbursing us, you will still be responsible in the event that the insurance company denies a claim or you have additional co-insurance or have not met your deductible. In the event that your insurance company does not pay, for whatever reason, it is your responsibility to pay the balance due. It is also your responsibility to then seek reimbursement from your insurance; Insights does not pursue denied claims on your behalf. As the insured, you are ultimately responsible for determining which services are covered by your insurance company. While we are providers for certain insurance companies, it is not the responsibility of Insights to know what your plan does and does not cover; plan coverage varies greatly. It is also your responsibility to alert us that you will be going through your insurance for services rendered at the outset of therapy. We are not able to back date claims or reimburse for sessions already paid for. If you have questions, about the payment process, please ask.

Initials:

AGREEMENT FOR FINANCIAL RESPONSIBILITY

The estimated cost of the evaluation will be discussed before the initial appointment. Half of the total cost of the evaluation must be received with your intake paperwork at the initial appointment. At the time of your final appointment and before receipt of the diagnostic report, the remainder of your balance is due in full. Cash, money order, check, MasterCard, or Visa are accepted. Insights will provide an itemized receipt of your payment, upon request, at the final meeting.

OTHER FEES

In the event that it is determined that Insights owes you a refund (example: insurance covered more than anticipated), Insights will issue you reimbursement. Please note that if a payment was made by credit card, there will be a 5% fee deducted from the refund. This fee can be avoided by paying with check or cash.

Insights will not agree to court appearances or other legal involvements unless the matter has been discussed and it is agreed that such involvement is within our range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, depositions and attorney consultations are \$300.00 per hour (two hour minimum) plus travel and waiting time, are non-discountable, and are payable in advance only.

CANCELLATIONS

Insights asks that you provide at least 24 hours notice prior to canceling an appointment. There is a \$150.00 charge for no-shows and late cancellations that must be paid immediately and is not eligible for reimbursement by insurance, and will not be applied to rescheduled evaluations. Please contact Insights regarding cancellations.

EMERGENCIES

Insights does not provide formal emergency services. Please visit our website for current office hours, If you are unable to reach anyone during office hours, please leave a message and your call will be returned as quickly as possible. Nighttime and weekend calls will typically be returned during business hours. If you find yourself in an urgent situation, please dial 911 or go to the nearest emergency room.

I understand that I am fully responsible for all fees incurred through Insights. I agree to pay all fees in full, including those that are not covered by my insurance company (unless otherwise agreed upon). I understand that my account may be turned over to a collection agency for non-payment after 30 days.

Please sign below indicating that you have read, understand, and agree to the information and terms of this document.

Patient's name

Signature of responsible person

Date

Insights Staff

Date