



Dear Parent (s):

Thank you for arranging a developmental evaluation appointment for your child. In order for us to schedule your appointments, we require the enclosed forms to be filled out and mailed back to our office. **Please attach a copy of the front and back of your child's insurance card.** Timely return of this information will ensure prompt response from our office.

The initial evaluation for a preschool age or younger child typically requires two 60-minute visits, usually about one week apart. An older child may need two 60-minute visits for history, physical, and neurological examination, developmental assessment and academic screening; followed by a 30-minute parent feedback visit that the child does not attend. You may want to arrange all of these appointments when you're starting the evaluation process, in order to schedule and complete them in a timely manner. Once the initial consultation is complete, regular follow-up visits may be required. A first-time medication consultation appointment requires one 60-minute visit. A medication follow-up appointment is usually 20-30minutes and a developmental follow-up is 60 minutes. You can expect a written letter within 3 weeks from the visit.

If any assessments have been performed, please send copies of pertinent evaluations of IEP's in advance by mail, or bring copies with you to the initial visit. Please do not fax this information.

Once we schedule your appointment(s), **we will need a referral from your primary care physician in order to hold the appointment. Please provide us with the referral number prior to your visit.** *If your insurer does not cover this service, you will be responsible for the fee's we charge.* If your child requires on-line or telephone management of 15 minutes or more, a code for case management will be billed to your insurance. Sometimes, a co-pay and referral are associated with this code.

You will need the following information to obtain this referral:

Lori Gara-Matthews, MD  
NPI #1790731362

or

Jennifer Lucarelli, MD  
NPI #1558660324

Please request 6 visits



We require credit card information *prior to all* developmental evaluations. Failure to provide this information will result in a dismissal of your appointment. If you need to cancel an appointment, please do so *24 hours prior* to the scheduled appointment time. Since one full hour has been allocated for these appointments, *you will be charged \$200 for missed appointments as well as cancellations without 24 hours' notice.*

Please try to hold non-urgent phone calls for medication, reports, etc. to Monday through Friday. Also, if your child is taking medication that requires a written prescription, please allow enough time for the prescription renewal to be written and sent to you before your medication runs out. If there is a medication side effect problem, someone is always available to assist you.

We look forward to working with you.

Sincerely,

Lori Gara-Matthews, MD

Jennifer Lucarelli, MD

Developmental Pediatricians



Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Sex: M/F (circle one) Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Billing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Guardian 1 Cell: \_\_\_\_\_ Guardian 2 Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent Information

Guardian 1 Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian 1 Occupation: \_\_\_\_\_ Language: \_\_\_\_\_

Guardian 2 Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian 2 Occupation: \_\_\_\_\_ Language: \_\_\_\_\_

I authorize the release of medical information necessary to process claims for medical benefits. I authorize and direct payments to Pediatric Healthcare for services provided. If my insurance does not allow full coverage for services provided, I understand that I will receive a patient statement for the balance.

Signature of Patient (if over 18 years old) or Parent: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



## PATIENT WAIVER

Due to the high cost of health care, many patients have elected insurance plans that have less expensive monthly premiums, but higher co-payments/deductibles. A deductible is a set amount, anywhere from \$100 - \$10,000, agreed upon between your insurance carrier and yourself, requiring the subscriber (you) to pay all costs up to the agreed amount before insurance will provide coverage. Please call your insurance company directly for specifics regarding your insurance plan.

Please note, as part of your child's developmental assessment, our providers will furnish a written letter of findings based upon a synthesis of information gathered through patient history, testing and scoring provided in our office and previous assessments provided. These additional fees can cost anywhere from \$250~\$500 and may not be covered by your insurance. You will receive a bill and be financially responsible.

***By signing below, I agree to assume full financial responsibility for any additional services provided to my child(ren) by Pediatric Health Care at Newton-Wellesley, P.C.. that my insurance plan may not cover.***

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Current Telephone Number: \_\_\_\_\_



## Credit Card Information Sheet

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Master Card: \_\_\_\_\_

Visa Card: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Number on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

I understand that I will be charged \$200.00 for my one-hour appointment if it is missed with a cancellation call at least 48 business hours prior

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you



Child's Name: \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

Person Completing form (Name/ Relation to child): \_\_\_\_\_

\_\_\_\_\_

**CURRENT CONCERNS**

Why are you seeking this evaluation?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BACKGROUND INFORMATION**

**Birth History**

Birth Weight: \_\_\_\_\_

Length of pregnancy (weeks): \_\_\_\_\_

Were there any prenatal complications? Please describe: \_\_\_\_\_

Were there any complications at delivery or after birth?

\_\_\_\_\_

\_\_\_\_\_

Does the child have any medical problems?

\_\_\_\_\_

\_\_\_\_\_

**MILESTONES** (provide age for those that apply)

First word: \_\_\_\_\_

First two-word sentence:

\_\_\_\_\_

Sitting: \_\_\_\_\_ Walking: \_\_\_\_\_

Potty-trained: \_\_\_\_\_

**EDUCATIONAL HISTORY** (provide setting for those that apply)

Daycare:

\_\_\_\_\_

Preschool:

\_\_\_\_\_

Elementary School:

\_\_\_\_\_

Middle School:

\_\_\_\_\_

High School:

\_\_\_\_\_

Other:

\_\_\_\_\_

Does the child have an IEP or 504 plan?

\_\_\_\_\_

(Please provide copies of the most recent version along with this intake form.)

**SERVICE HISTORY** (please specify dates and setting; i.e. private or school-based)

Early Intervention \_\_\_\_\_

Speech Therapy: \_\_\_\_\_

Occupational Therapy or Physical Therapy:

\_\_\_\_\_

Therapy/ mental health services:

\_\_\_\_\_

Other (social skills groups, etc):-

\_\_\_\_\_

Have prior evaluations been completed (school-based, neuropsychological, Early Intervention)?

\_\_\_\_\_

\_\_\_\_\_

(Please provide copies of the most recent version along with this intake form.)

**SOCIAL HISTORY**

Who does the child live with?

\_\_\_\_\_

Mother's age and occupation:

\_\_\_\_\_

Father's age and occupation:

\_\_\_\_\_

Sibling(s) name and age(s):

\_\_\_\_\_

\_\_\_\_\_

Is there a family history of any of the following (if so, please specify relation to child)

Learning disabilities, Autism Spectrum Disorder, Speech Delay, Genetic conditions, Epilepsy/ Seizures, Depression, Anxiety, Other developmental disorders, other mental health conditions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_