LOWER FALLS
PEDIATRICS

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
Please request 6 visits

In order to book a Developmental Evaluation, we must have credit card information on file. If you fail to cancel the appointment without providing 72 hours' notice OR miss the appointment, there is a $200 fee that will be charged to the card on file.

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.

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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

Parent/Guardian 1 Name: _____ DOB: ____/_____/____

Occupation: _____ Language: _____

Parent/Guardian 2 Name: _____ DOB: ____/_____/____

Occupation: _____ Language: _____

Marital Status (circle one): Married Separated Divorced
If Separated or Divorced, which parent has primary custody? _____

Health Insurance: _____ ID #: _____
Name of Insurance Holder: _____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize and direct payments to Lower Falls Pediatrics 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.

Parent Signature: _____

Print Name: _____ Date_____/_____/_____

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PATIENT WAIVER

Date: _____

Patient Name: _____ Patient DOB: _____

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~$800 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 Lower Falls Pediatrics, P.C. that my insurance plan may not cover.

Parent Signature: _____

Cancelled or Missed Appointments:

I understand that if I fail to cancel the appointment without providing 72 hours' notice OR miss the appointment, there is a $200 fee that will be charged to the card on file.

Cardholder Name: _____

Cardholder Signature: _____

Master Card: _____ Visa Card: _____

Number on Card: _____ Security Code (CVV)_____

Expiration Date: _____

LOWER FALLS PEDIATRICS

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:

_____

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:

_____

_____