CARDINAL
CLINICAL CONSULTING

We have received a referral from your child's provider requesting a psychological evaluation.

Due to the demand for these services, we have a waiting list that you will be added to. **In order to have your appointment scheduled, please review and complete the following paperwork**. If you would like us to check to your insurance coverage for psychological testing, please complete that information on page 2 or send a copy of your card.

Once this packet is completed, you can return it to our office by mail, fax, or email. Our scheduling is based on those who have completed their paperwork. Once your name approaches the top of our waiting list, we will contact you to schedule an appointment. In addition to the requested information, please send any previous testing (e.g., school testing, other evaluations, any IEP documents, etc.) that you may have.

If you have any questions about the information in this packet, feel free to contact the clinic at (662) 269-3599.

To return this packet:

Mail to:

Cardinal Clinical Consulting
P.O. Box 3897
Tupelo, MS 38803

Scan and email to:

info@cardinalclinical.com

Fax to:

662-269-2503

Cardinal Clinical Consulting, LLC
662-269-3599

New Client Information

Today's date: ___/____/____

Name of person completing this packet: _____

Relationship to the child: _____

Please attach a recent photo of your child for use in our file

Client information

Name of child: _____
(First) (Middle) (Last)

Preferred name? _____ **Date of birth: ___/____/_____**

Sex: ☐ Male ☐ Female **Age: _____**

Ethnicity: ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino

☐ Native American ☐ White/Caucasian ☐ Other:

Address: _____

City: _____ State: _____ Zip: _____

Contact Information *Please check the box next to your preferred method(s) of contact*

Parent/Caregiver Name: _____

☐ **Phone: (___) ____-_____** ☐ **Cell: (___) ____-____** ☐ **Work: (___) ____-_____**

☐ **Email: _____**

Other Parent/Caregiver Name:_____

☐ **Phone: (___) ____-_____** ☐ **Cell: (___) ____-____** ☐ **Work: (___) ____-_____**

☐ **Email: _____**

May we leave a message on your answering machine? ☐ No ☐ Yes

Insurance Information

NOTE: You may send a photo of the front/back of your card instead of filling this section out

Insured's Name: _____ Insured's D.O.B.: ____/____/_____

Insurance Plan Information:_____
Company Group/Policy # Member ID

Referral Information

Who referred you to us? If you found us on your own, please list where you heard about us.

Name: _____

Phone number: (____) _____-_____ **May we contact this person?** ☐ Yes ☐ No

How do you know this person?

☐ Physician/pediatrician ☐ Relative ☐ Friend ☐ School staff

☐ Early Intervention specialist ☐ Other: _____

When did you first become concerned about your child's development?

What were your initial concerns?

What are your current concerns/reasons for requesting this evaluation?

Has your child been tested or diagnosed previously? If so, please list below and provide copies of any evaluation results.

Diagnosis (e.g., Autism, Asperger's, ADHD, etc.)	When was it made?	Who made it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Information

With whom does the child live? (check all that apply)

□ Biological mother □ Biological father □ Stepmother □Stepfather

□ Adoptive mother □ Adoptive father □ Foster mother □ Foster father

□ Grandmother □ Grandfather □ Split time between two homes

□ Other: _____

Who has legal custody of the child? (If applicable) _____

Please provide all relevant custody or court documents prior to first appointment

Parent(s)/Primary Caregiver(s) Information:

Name: _____ Date of Birth: ____/_____/_____

Occupation: _____ Highest grade completed: _____

Relationship to child: _____

Name: _____ Date of Birth: ____/_____/_____

Occupation: _____ Highest grade completed: _____

Relationship to child: _____

Please list other siblings/children in the home:

Name	D.O.B.	Gender	Relationship	Lives at home?
Example: Jane Doe	*1/1/2001*	*Female*	*Half-sister*	*Part-time*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medical Information

Primary Care Physician:

Name: _____ Specialty: □ Family practice □ Pediatrics

_____ □ Other: _____

Address: _____

Phone: (___) ____ - _____

Pregnancy History:

This section is to be completed by the mother of the child, if possible. If by another person, please indicate who completed it:

Was this child a planned pregnancy? □ Yes □ No

Number of pregnancies: _____

This child was pregnancy number: _____

Number of live births: _____

Number of miscarriages: _____

Number of still births: _____

Number of living children: _____

Age of mother at delivery _____ Age of father at delivery _____

Did you have any problems during this pregnancy? □ Yes □ No

If yes, please describe:

Did you take any medication during this pregnancy? □ Yes □ No

If yes, please list:

Did you smoke during this pregnancy? □ Yes □ No

Did you use alcohol or other drugs during this pregnancy? □ Yes □ No

If yes, please describe:

Medical Information (continued)

Birth History:

Birth weight: _____ pounds _____ ounces Gestational age: _____ weeks

Delivery: □ Vaginal □ C-section Labor: □ Spontaneous □ Induced □ Unsure

Where was this child born? _____
(Hospital) (City/State)

Were there any difficulties with delivery? □ Yes □ No
If yes, please indicate any that apply or describe in more detail.

□ Jaundice □ Meconium in the amniotic fluid □ Cord around the neck

□ Difficulty breathing □ Other/describe:

Was your child admitted to the neonatal intensive care unit (NICU)? □ Yes □ No
If yes, please describe:

Length of time in hospital after birth: _____

Developmental Information

Do you feel your child's development was faster or slower than other children?

□ Faster □ Slower □ As expected

Please explain:

At what age did your child:

Milestone	**Age**	**Milestone**	**Age**
Sit alone		Smile at others	
Crawl		Walk	
Make meaningful sounds (cooed/babbled)		Said single, recognizable words	
Combine words into 2-3 word phrases (such as, "drink milk")		Use sentences (such as "want more snack")	

How much of your child's speech do you understand? _____ %

How much do you think a stranger could understand? _____%

If your child uses spoken language, please give an example of what he/she might say (for example, to ask for something like a food or toy):

Is your child toilet trained? ☐ Yes, at age:_____ ☐ No ☐ Partially
If partially, please explain:

Has your child ever failed to progress in development? ☐ Yes ☐ No
If yes, please explain:

Has your child ever lost any skills or gone backwards in development? ☐ Yes ☐ No
If yes, please explain:

For older children and adolescents, has your child started puberty? ☐ Yes ☐ No

Medical History:

Does your child take medication? ☐ Yes ☐ No
If yes, please provide the name of the medication, the dosage, and the prescriber.
Example: Methylphenidate (Concerta), 54mg—from pediatrician Dr. Smith

Does your child have any known allergies? ☐ Yes ☐ No
If yes, please describe:

Has your child ever been hospitalized? ☐ Yes ☐ No
If yes, please describe why and include child's age/time of hospitalization:

Has your child ever had surgery? ☐ Yes ☐ No
If yes, please describe the reason for surgery and child's age/when it occurred:

Has your child ever had a seizure? ☐ Yes ☐ No

Medical Information (continued)

Is your child up-to-date on his/her immunizations? ☐ Yes ☐ No

Please bring your child's immunization card or copy and attach it to this paperwork

Please check any condition or symptoms that your child has experienced:

☐ Allergies	☐ Colic	☐ Head injuries	☐ Rashes/eczema
☐ Anemia	☐ Constipation	☐ Heart problems	☐ Reflux
☐ Apnea	☐ Convulsions/seizures	☐ Measles	☐ Spina bifida
☐ Asthma	☐ Diabetes	☐ Meningitis	☐ Staring spells
☐ Brain infection	☐ Diphtheria	☐ Mumps	☐ Stomach problems
☐ Broken bones	☐ Eye problems	☐ Obesity	☐ Swallowing issues
☐ Cerebral palsy	☐ Fainting spells	☐ Pneumonia	☐ Tics/twitches
☐ Chicken pox	☐ Frequent diarrhea	☐ Poisoning	☐ Tonsillitis

Please explain any problems indicated above or other medical issues experienced (include child's age at the time of problem)

Has your child ever seen any of the following specialists? (Check all that apply)

☐ Gastroenterologist	☐ Neurologist	☐ Psychiatrist	☐ Geneticist
☐ Feeding specialist	☐ Cardiologist	☐ Other: _____	

Please describe the reason for visit and any relevant results:

Hearing:

Do you feel your child has difficulty hearing? ☐ Yes ☐ No
If yes, explain:

Has your child had a hearing evaluation? ☐ Yes ☐ No
If yes, date of your child's latest evaluation: ___/____/_____ ☐ Pass ☐ Did not pass

Has your child had P.E. tubes placed in the ear? ☐ Yes ☐ No
If yes, at which age(s)? ____

Medical Information (continued)

Vision:

Do you feel your child has difficulty seeing? ☐ Yes ☐ No
If yes, explain:

Has your child had a vision test? ☐ Yes ☐ No
If yes, date of your child's latest evaluation: ___/____/_____ ☐ Pass ☐ Did not pass

Have glasses ever been prescribed for your child? ☐ Yes ☐ No
Does your child wear glasses now? ☐ Yes ☐ No

Diet/Nutrition:

Has your child ever been on a special diet? ☐ Yes ☐ No
If yes, please describe:

Please list any concerns you may have about your child's diet or nutrition:

Family Medical History

If any of the child's biological relatives have had any of the following conditions, please check the box next to the condition and write that person's relationship to the child (e.g., uncle – mother's side) next to it.

Condition	Relationship to child	Condition	Relationship to child
☐ Autism Spectrum Disorder		☐ Alcohol/Drug abuse	
☐ Intellectual disability		☐ Birth defects	
☐ Developmental delay		☐ Cerebral palsy	
☐ Speech/language disorder		☐ Suicide	
☐ ADHD		☐ Depression	
☐ Learning Disability		☐ Anxiety disorders	
☐ Birth defects		☐ OCD	
☐ Seizures or epilepsy		☐ Bipolar disorder	
☐ Tourette's disorder/Tics		☐ Schizophrenia	
☐ Rett's Disorder		☐ Cancer	
☐ Other/more information:			

Behavioral Information

Do you have any concerns about the management of your child's behavior? □ Yes □ No
If yes, please explain:

Does your child receive any therapy services, previously or currently? □ Yes □ No
If yes, please explain:

Does your child tend to worry more than other children? □ Yes □ No
If yes, please provide an example:

How do you discipline your child?

Are these discipline methods effective? □ Yes □ No

How does your child respond to frustration?

What toys or activities does your child enjoy?

What do you consider to be your child's strengths?

What other information do you think is important to know about your child?

Educational History

Has your child ever received Early Intervention Services? ☐ Yes ☐ No

If yes, indicate all that apply:

☐ Special instruction ☐ Speech therapy ☐ Occupational therapy ☐ Physical Therapy

Please indicate at what ages your child received these services and if they are still ongoing:

Current School/Daycare: _____ Grade: _____

City/State: _____

Has your child ever repeated a grade? ☐ Yes ☐ No

If yes, which grade(s):

Does your child have an IEP or a 504 Plan? ☐ Yes ☐ No

If yes, what services does your child receive?

Please bring a copy of your child's latest IEP or 504 plan to the appointment if available

Thank you for completing this information! Please read and sign the following pages regarding the clinic's policy and procedures.

Once we receive your completed packet, you will be added to our scheduling list. If you have questions, including to check the status of your appointment, please call us at 662-269-3599.

No-Show and Cancellation Policy

Appointments may be rescheduled if advance notice is given and alternative appointment times are available. A missed or cancelled appointment is disruptive to the operation of the clinic, and it impacts the psychologist, the client, and other clients who could have potentially utilized that time slot. As a result, we reserve the right to charge a late cancellation or no-show fee of no more than $200, based on our usual billing rates.

A "no-show" is missing a scheduled appointment without any notification prior to the scheduled appointment time. A "late cancellation" is cancelling an appointment within 24 hours of the scheduled appointment time. This means that if an appointment is scheduled for 9:00 a.m. on a Thursday, you must cancel your appointment by calling or emailing our clinic by 9:00 a.m. on Wednesday (please note: a Monday appointment must be cancelled by the Friday before the appointment). Consideration of extraordinary circumstances may occur on a case-by-case basis. For example, if your child or other family members have been ill, we will cancel and reschedule your appointment without penalty.

Clients who no-show for an appointment will NOT be automatically rescheduled. If the client initiates a phone call requesting to be rescheduled after a no-show, they may first be returned to the waiting list.

No-show/late cancellation fees are the full responsibility of the client.

By signing below, you are agreeing to the terms of this policy and you acknowledge your responsibility in making scheduled appointments.

_____ _____

Printed name of person completing this form Date

_____

Signature

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal representative.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases further risk.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described under #1 and #2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another

licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION.

_____ _____

Printed name Date

_____

Signature

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PANDEMIC

This document contains important information about our decision (yours and mine) to attend in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being. If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk), though we will attempt to minimize these risks within our office: my staff and I will wear protective facemasks, employ the use of air purifiers throughout the office, and frequently wash and sanitize our hands and objects used during appointments.

If You or I Are Sick

You understand that I am committed to keeping you, me, my staff, and all of our families safe from the spread of this virus. If you show up for an appointment and I or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. If I or my staff become ill, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I am required to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without additional consent.

Informed Consent

This agreement supplements the general informed consent policy. Please let me know if you have questions about these efforts. Your signature below shows that you agree to these terms and conditions; when you sign this document, it will be an official agreement between us.

_____ _____

Patient/Responsible Party Date