**Child and Adolescent Health Specialists, PC**

**DEVELOPMENTAL-BEHAVIORAL PEDIATRICS**

**Robert F. Belknap, MD, MPH, FAAP**
**Nicola J. Smith, MD, FAAP**
**Katherine A. Trier, MD, FAAP**

## About Developmental-Behavioral Pediatrics

Thank you for your interest in Developmental-Behavioral Pediatric Services at Child and Adolescent Health Specialists, PC. Dr. Belknap, Dr. Smith and Dr. Trier have many years of experience specializing in diagnosing and treating children with autism spectrum disorders, problems of attention/learning, many mood disorders, developmental delay and behavior problems associated with these issues. Dr. Belknap, Dr. Smith and Dr. Trier are certified as diplomates in Developmental-Behavioral Pediatrics by the American Board of Pediatrics.

***For additional information see our website: www.childhealthspecialists.com***

## Insurance/Billing/Referrals

Our office will submit claims for Developmental-Behavioral appointments to the insurances with which we are contracted, including most major health insurances. You can verify we are in your specific plan network on your insurance website ("Find a Doctor") or by calling your member services department. *Please note we are contracted medical providers, **not** mental health.*

If your child is covered by any insurance that does not list our providers, we recommend that you call the insurance company to verify whether they will reimburse for these services as "out of network." In that case, you would be required to pay the full amount at the time of the appointment. We will give you a receipt with the appropriate codes to submit to your insurance company for reimbursement.

If your insurance is an **HMO**, you will need to obtain a referral from your primary care doctor (PCP). If you wish to be placed on our cancellation list for a sooner appointment, you may request that your doctor date the referral effective the day you call for it rather than the date of the appointment you were originally given. Otherwise, in the event that your appointment is moved to an earlier time, your primary care doctor would need to provide a new referral reflecting the new date. **If you do not have a referral on the date of your appointment, you will be required to pay for the visit in full in advance.** You may then submit our statement to your insurance company for reimbursement.

To bill any insurance company for a consultation appointment, a request from a professional is required. If you have an HMO, the referral from your child's PCP will serve as this request.

If your insurance is a **PPO**, we will need a written request for a consultation from the referring provider, whether this is your PCP, a therapist, teacher, etc. Please have the enclosed **Request for Consultation** form completed by your referring professional.



223 Chief Justice Cushing Highway, Suite 201, Cohasset, MA 02025 ◆ T. 781.383.8380 ◆ F. 781.383.8382 ◆ www.drbelknap.com

## Scheduling Appointments

To schedule an appointment, complete and return the enclosed registration packet as soon as possible*. We will review your information to determine the appropriate type and time for your appointment(s). Following review, our office will contact you to schedule your appointment(s).

## Outside Testing/Reports

Please bring copies of any relevant information to our office on the day of your appointment (eg. IEP, most recent school testing or reports, other evaluations). Please bring copies, **not** originals. Our office will not be able to copy them for you and we will not be responsible for loss of the originals. If you wish to have copies of any materials that Dr. Belknap, Dr. Smith or Dr. Trier send home for completion (e.g. developmental questionnaires), please copy them **prior** to returning them to the office. We will not be able to copy them for you and originals must be kept as part of our medical records.

## The First Consultation Visit

We recommend that children other than the one who is being seen for the appointment **not** accompany you to the appointment as this can be a significant distraction. Children must be over 8 years of age to remain in the reception room without adult supervision. Please set aside approximately 1 ½ hours for your initial consultation appointment.

All efforts are made to make your child's experience comfortable. A nurse will obtain measurements, vital signs, and typically will perform an evoked otoacoustic hearing evaluation, and a vision screening (3 years of age or greater).

Following your consultation appointment, a summary letter will be sent to the referring physician or other professional with a copy to the parents.

Please be aware that additional reports (e.g. letters to schools) are typically not covered by health insurance plans. Such requests will require payment in advance.

## Neurodevelopmental Testing Appointments

The doctor may schedule your child for neurodevelopmental testing following your consultation. Please set aside approximately 1½ hours for this appointment. Note that this is not the same testing provided by schools for a school based evaluation and it is not a Neuropsychological Evaluation. Either of these may be recommended depending on the doctors findings.

***The registration forms should be filled out with black or blue ink as other colors will not show through fax or scanner.**

Please feel free to call our office if you have any additional questions or concerns.



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☐ **First Available**

## PATIENT REGISTRATION FORM

| | | | | |
|---|---|---|---|---|
| Child's First Middle Last Name | | | Date of Birth | Sex |
| Street Address City State Zip | | | | |
| Preferred Phone # (for office to contact you) | How did you hear about us? ❑ Physician ❑ Family/Friend ❑ Mailing ❑ Newspaper ❑ Internet ❑ Other _________ | | | |
| Ok to leave messages Voice ❑ or Text ❑ | Email address for Office News and Updates and other correspondence | | | |
| Parent A.Mother's Name (Father if 2 dad family) | Parent B. Father's Name (Mother if 2 mom family) | | Parent's Marital Status S M D W | |
| Legal Guardian (if different from above) or if divorced, who has legal and physical custody (Legal documentation required if not joint custody) | | | | |
| Parent/Guardian Street Address (if different from above) City State Zip | | | | |
| Parent/Guardian Home Phone # | Parent A Cell Phone # | Parent B Cell Phone # | Work # if ok to call | |
| Next of Kin/Emergency Contact Name | | Relationship | Telephone # | |

### PRIMARY INSURANCE COMPANY – EFFECTIVE DATE ____________

| | | | |
|---|---|---|---|
| Name of Insurance Company | Policy ID # | | Group # |
| Claims Address City State Zip | | | Telephone # |
| Name of Policy Holder | Date of Birth | Relationship to Insured | Type of Plan- HMO, PPO<br>Deductible?<br>Referrals Needed? |
| Employer Name and Address | | | |

### SECONDARY INSURANCE COMPANY – EFFECTIVE DATE _____________

| | | | |
|---|---|---|---|
| Name of Insurance Company | Policy ID # | | Group # |
| Claims Address City State Zip | | | Telephone # |
| Name of Policy Holder | Date of Birth | Relationship to Insured | Type of Plan- HMO, PPO<br>Deductible? Referrals? |
| Employer Name and Address | | | |

### ASSIGNMENT OF BENEFITS

**I understand that I am responsible for payment in full of all charges**. I request that payment of authorized insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

Signature ___________________________________________________Date ________________



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## PATIENT HISTORY FORM

**Child's Name:** ________________________________________ DOB: ____________

**Your Name:** _____________________________ Relation to child: ________________

**Child lives with:** __________________ Relation to Child: ________ DOB:__________

**Language (s) Spoken at Home:** ________________________________

**Ethnicity:** _________________________ **Race:** ________________

**Referred by:** ___________________________________________________________

**Has your child ever been seen by one of our specialists?** Yes No If yes, when _______

**Any Previous Evaluations / Testing?** Yes No If yes,

Where: _________________ Performed by:___________________________________

When: __________________

What did you learn from this? _______________________________________________

**Current or Previous Diagnoses:** _____________________________________________

**Name of School / Daycare:** _________________________________________________

Address:_______________________________________________________________

**Is your child currently on an IEP or 504 plan?** Yes No

**Date of last school-based evaluation:** ____________________

**How would you rate your child's school performance at this time?**

____ Good ____ Fair ____ Poor

**Child's Primary Care Physician**:_____________________________________________

Address: _______________________________________________________________

Telephone: __________________

**Current Medication(s)**: ____________________ Dose ___________

____________________ Dose ___________

____________________ Dose ___________

**Name of doctor who is currently managing medications**: ________________________



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**Please list previous medications and reason for discontinuation:**

______________________________________________________________________

______________________________________________________________________

**Is your child currently receiving or has s/he in the past received any services or therapies?** (e.g. Speech, Occupational, Physical Therapies, ABA, other)
Please include dates, where performed, and frequency.

______________________________________________________________________

______________________________________________________________________

**Has your child been seen or currently being followed by any other Specialists?**
Yes No If so when, by whom:

______________________________________________________________________

______________________________________________________________________

**Please indicate if your child has experienced any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Seizures | No | Yes | Weight loss or gain | No | Yes |
| Tics (repetitive movements or sounds) | No | Yes | Problems with urinating or with kidneys | No | Yes |
| Easy bleeding/bruising | No | Yes | Constipation or diarrhea | No | Yes |
| Heart beating “funny” or fast | No | Yes | Abdominal pain | No | Yes |
| Chest Pain | No | Yes | Rash or other skin problem | No | Yes |
| Difficulty breathing | No | Yes | Broken bone | No | Yes |
| Problems with hearing | No | Yes | Problems with vision | No | Yes |
| Problems with immune system | No | Yes | Recent febrile illness | No | Yes |

**To assist us in making an accurate assessment of your child’s issues, we need a detailed picture of your child’s development and behaviors. Please answer the following questions to the best of your ability. Completion of this detailed history will allow more time for discussion and observation during your appointment.**



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Were there any concerns during the pregnancy? ___________________________________

___________________________________________________________________________

___________________________________________________________________________

Were there any medications taken besides iron and vitamins?

☐ Yes, Please list ☐ No

_________________ _____________________ ____________________

Any alcohol ☐ Yes, Please list amount/frequency _________________________ ☐ No

Drugs ☐ Yes, Please list amount/frequency ______________________________ ☐ No

Cigarettes ☐ Yes, Please list amount/frequency ___________________________ ☐ No

Any particular stressors ☐ Yes ☐ No Please describe if yes ________________________

___________________________________________________________________________

___________________________________________________________________________

Was this pregnancy Full-term? ☐ Yes ☐ No ______________________________________

Type of delivery? _______ If C-section reason __________________Birth weight? ________

Any troubles at the time of birth or while in the hospital? ____________________________

___________________________________________________________________________

___________________________________________________________________________

After coming home, what was your child like as a baby? ______________________________

___________________________________________________________________________

Any feeding issues or colic? ________________

Any trouble establishing rhythms of eating and sleeping? ____________________________

___________________________________________________________________________

Any problems with typical milestones such as sitting, standing, or walking? _____________

___________________________________________________________________________

Did s/he babble (e.g. *dada, baba*) before 12 months? ☐ Yes ☐ No



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How old when s/he said first word? ___________ Put 2 words together? _______________

When you called his/her name at 10 months of age, did s/he look at you? ☐ Yes ☐ No

Did s/he follow where you were pointing to an object of interest? ☐ Yes ☐ No

Did s/he point to objects of interest to him/her as he got a little older? ☐ Yes ☐ No ☐ Sometimes

Did s/he bring books or games to you to play with him/her after s/he learned to walk? ☐ Yes ☐ No

What was his/her play like when s/he was 18 months of age? __________________________

______________________________________________________________________________

Did s/he like miniatures such as toy kitchen sets, tool sets, farm animals, etc.? ☐ Yes ☐ No

Between 2 and 3 years of age did you see make-believe play begin? ☐ Yes ☐ No

Did you ever see him/her focus in an unusual way at a part of a toy such as a wheel or a reflection of light on a toy? ☐ Yes ☐ No

Did s/he ever pass objects slowly in front of his/her eye or look at them only from the side? ☐ Yes ☐ No

Has your child ever displayed rituals or obsessions or other repetitive behaviors? ☐ Yes ☐ No

If yes, please describe and indicate age when first appeared:_____________________________

______________________________________________________________________________

When did s/he feed himself independently with fork, cup and spoon? ____________________

When did s/he assist with dressing and undressing? _________________________________

When was s/he toilet trained? __________________________________

Any difficulties with learning how to use buttons, snaps and zippers? ☐ Yes ☐ No



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Did your child receive Early Intervention services (below 3 yrs) ☐ Yes ☐ No If so, what type of service and for how long? ________________________________________________

______________________________________________________________________

Did s/he go to preschool or daycare? ☐ Yes ☐ No

Were there any problems there? ☐ Yes ☐ No Was s/he able to follow a routine? ☐ Yes ☐ No

Did s/he show interest in what other children were playing? ☐ Yes ☐ No

Did s/he want to join in with their play after age 4? ☐ Yes ☐ No

Were there difficulties with the transition to kindergarten ☐ Yes ☐ No

Has s/he had any problems learning sounds associated with symbols such as letters and numbers? ☐ Yes ☐ No

Is s/he hypersensitive to touch (tags bother, sock line has to be "just right") ☐ Yes ☐ No

Is s/he either attracted to or repelled by any types of food including issues of texture, taste or smell? ☐ Yes ☐ No

Does s/he seek out physical play or pressure? ☐ Yes ☐ No

Is s/he hypersensitive to sounds? ☐ Yes ☐ No

Does your child strongly react to change, such as stopping a favorite activity to go in the car? ☐ Yes ☐ No

In general, have these problems improved over time? ☐ Yes ☐ No

Does s/he notice familiar routes in the car and comment on them? ☐ Yes ☐ No

Does s/he get upset if there is a deviation from the expected route/routine? ☐ Yes ☐ No

Does s/he have any intense interests (e.g. a subject that s/he knows everything about, or a topic that s/he persistently returns to in conversation or play)? ☐ Yes ________________ ☐ No



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Does s/he have any difficulty socializing or making friends? ☐ Yes ☐ No

Are you concerned about her/his ability to play (eg. parties and playdates)? ☐ Yes ☐ No

Is s/he interested in sports? ☐ Yes ☐ No

Are you concerned about her/his motor coordination? ☐ Yes ☐ No

Does s/he understand facial expressions? ☐ Yes ☐ No

Can s/he carry on a typical back and forth conversation? ☐ Yes ☐ No

Do you have any concerns about his/her diet? ☐ Yes ______________________________ ☐ No

Does s/he eat breakfast? ☐ Yes ☐ No

Are there any problems with elimination (e.g. urinating/defecating)? ☐ Yes ___________ ☐ No

Does s/he have any allergies? ☐ Yes ___________________________________________ ☐ No

Has s/he ever lost consciousness or had a serious head injury? ☐ Yes ☐ No
If Yes give details:____________________________________________________________________

Please explain any visits to the emergency room or surgeries: ____________________________

______________________________________________________________________________

______________________________________________________________________________

Have there ever been any unusual episodes in which you thought s/he was "not there" or possibly having a seizure? ☐ Yes ☐ No

What time does your child get into bed at night? __________________________________________

How long does it take him/her to fall asleep? _____________________________________________

Does s/he routinely wake up during the night? ☐ Yes ________________________ ☐ No

Is s/he a restless sleeper? ☐ Yes ☐ No

Does s/he snore? ☐ Yes ☐ No

Have you ever thought that s/he might have stopped breathing during sleep? ☐ Yes ☐ No



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At what time does s/he usually wake up in the morning? ________________________________

Does s/he seem rested in the morning? ☐ Yes ☐ No

How long have you lived in your present home and community? _________________________

Are there any particular stresses at home? ____________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Who lives in the home and what is their relation to your child? ___________________________

________________________________________________________________________________

________________________________________________________________________________

Parent A age/education/occupation: _________________________________________________

Parent B age/education/occupation: _________________________________________________

**FAMILY HISTORY: Please indicate conditions that run in the family by writing the relation of the person to your child e.g. Maternal/Paternal grandmother, brother** (include grandparents, aunts & uncles)

School Problems
No Yes __________________

Attention Disorders
No Yes __________________

Learning Disability
No Yes __________________

Anxiety Disorders
No Yes __________________

Tics/Tourette Syndrome
No Yes __________________

Panic Attacks
No Yes __________________

Depression
No Yes __________________

Suicide Attempts
No Yes __________________

Alcoholism
No Yes __________________

Other Mental Health issues
No Yes __________________

Autism/PDD/Asperger Syndrome
No Yes __________________

Genetic Disorders
No Yes __________________

Mental Retardation
No Yes __________________

Seizures/Epilepsy
No Yes __________________

Hereditary deafness or blindness
No Yes __________________

Allergy/Asthma
No Yes __________________

Heart disease before 50 years of age
No Yes __________________

Unexpected/unexplained death
No Yes __________________

Substance Abuse
No Yes __________________

Any other problems of development
No Yes __________________



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**What specific questions or concerns do you wish to be addressed?**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

***Please Note: A parent or legal guardian must accompany any minor child to a developmental-behavioral pediatric appointment.***

As a reminder, we recommend that children other than the one who is being seen for the appointments, not accompany you to the appointments as this can be a significant distraction. We realize sometimes this is not possible. In this case please bring something to occupy your child for approximately 1 1/2 hours.

Children must be over 8 years of age to remain in the reception room without adult supervision.



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## NOTICE OF HIPAA PRIVACY PRACTICES

***This is a summary of how we use and disclose your Protected Health Information. Please read the full Notice of Privacy Practices available on our web site or at our front desk or request a copy to be mailed to you, prior to signing this form.***

A. We have a legal duty to protect health information about you.

B. We may use and disclose Protected Health Information or "PHI" about you in the following circumstances: ***see full Notice of Privacy Practices for examples***

   1. We may use and disclose PHI about you to provide health care treatment to you.
   2. We may use and disclose PHI about you to obtain payment for services.
   3. We may use and disclose your PHI for health care operations.
   4. We may use and disclose PHI under other circumstances without your authorization, such as when required by law or for public health activities.
   5. You can object to certain uses and disclosures.
   6. We may contact you to provide appointment reminders by voice message, text or email.
   7. We may contact you with information about treatment, services, products or health care providers.
   8. We may contact you for fundraising activities.

Any other use or disclosure of PHI about you requires your written authorization.

C. You have several rights regarding PHI about you.
   1. You have the right to request restrictions on uses and disclosures of PHI about you.
   2. You have the right to request different ways to communicate with you.
   3. You have the right to see and copy PHI about you.
   4. You have the right to request amendment of PHI about you.
   5. You have the right to a listing of disclosures we have made.
   6. You have a right to a copy of this notice.

D. You may file a complaint about our privacy practices. ***See full Notice of Privacy Practices for instructions.*** Contact the Office Manager with questions or concerns.

E. A copy of the full description of Child and Adolescent Health Specialists, PC privacy practices has been made available to me. I understand my rights and how my protected health information can be used by Child and Adolescent Health Specialists, PC.

This Notice of Privacy Practices is effective as of today's date: ______________________

Patient's Name: _______________________________________________

Parent/Guardian Signature: _______________________________________



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## CANCELLATION and PAYMENT POLICY

**Child's Name:** ___________________________________ **Date of Birth:** ______________

Due to the considerable time involved with Developmental Appointments, our office has developed the following Cancellation and Payment Policy:

- **Consultation and Testing appointment cancellations require 5 days notice during regular business hours, to avoid incurring a charge of $300.00.**

- **Follow Up appointment cancellations require *48* hours notice during regular business hours to avoid incurring a $150 charge.**

*Calls for cancellations must be received during regular business hours Monday-Friday. Calls will not be accepted by the afterhours emergency answering service for cancellations.*
*Monday appointments must be cancelled by 5pm the preceding Friday.*

An active credit card number is required to be kept on file with our PCI compliant secure gateway, to which we will bill all outstanding balances which may include deductible, copayment/coinsurance, appointments missed or cancelled without required notice, insurance denials for non-covered services, partial payment, no referral or inactive insurance.

Your signature below indicates that you authorize Child and Adolescent Health Specialists, PC to charge your credit card for patient balances as listed above. A receipt will be sent to you once your payment has been processed.

Credit Card to reserve your appointment time: Type: (circle one) MasterCard or Visa

Name on Card: ____________________________________________________

Credit Card #: ____________________________________________________

Expiration Date: ____________________________________________________

CV # (3 letter code on back): ______________________________________________

**Cardholder's SIGNATURE:** ____________________________ **Date**: __________

* ***We cannot schedule your appointment until we have received pages 3-15.***

Upon receipt of **all pages** our office staff will contact you to schedule your appointment.



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**Insurance and Billing Information:**

**Our office will submit claims for Developmental-Behavioral appointments to all insurances we are contracted with if you have a verifiable active policy.**

The following is a list of our most commonly applied insurance codes for Developmental-Behavioral Appointments. *Please note this is not an inclusive list and may change without notice.* If you have any questions or concerns about what your insurance will pay, or **if you have a deductible plan**, please contact your insurance provider's member services department for ***medical services*** prior to scheduling your appointment (s). Your insurance is required to inform you of your responsibility for services within 2 business days of your request. Please call our office if your insurance denies any of the codes listed below. By signing this waiver you understand that you are responsible for payment of non-covered procedures and insurance determined balances and agree to payment via your credit card on file.

**Developmental Behavioral Pediatrics Codes:**
***Consultation visit:***
Developmental-Behavioral Consultation, new patient (99245,99244) or (99205+99354/9355 for Blue Cross, Fallon, MassHealth-consultation codes not covered) 99354/9355 not covered by BC, Mass Health.
Otoacoustics Emissions hearing screening (92587) Vision screening (99173)
Assessment and screening questionnaires (96127,96110, 96160, 96161) more than one screening may be administered, insurance may only pay for 1, or charge to deductible, any not covered are patient/parent responsibility)
***Neurobehavioral Testing Appointment***
Developmental Testing (96116/**96121** or 96112/**96113**) #units may exceed allowed and not be covered.
***Parent Conference*** Office visit codes - 99214 or 99215
***Follow up appointments*** Office visit codes 99213, 99214, 99215.
**Prolonged visit code** - if your parent conference or follow up appointment runs longer than 40 minutes (99354,99355) ***Not covered by certain insurances***- BC, HP, MassHealth, others
**Review of records outside of your appointment time** (99358) ***Not covered by certain insurances***

Please be aware that review of records outside of your appointment time, requests for telephone consultations with parents, therapists, or school personnel and **additional** reports (e.g. letters to schools) will not be covered by your insurance and will require payment in advance.

This list is representative but not inclusive **I understand that these or other applicable codes may not be covered by my insurance or may be subject to my deductible and if not paid by my insurance, I am responsible for payment in full. I understand I may contact my insurance prior to my appointment to verify coverage for these services, otherwise they will become my responsibility.** A copy of the *Office Financial Policies* has been made available to me via the website. I understand that balances are due upon receipt and are subject to a $10 billing fee if payment or a payment plan is not addressed within 30 days. Returned checks or declined charges will incur a $25 fee.

Child's Name: ________________________________ Date: _______________

Parent/Guardian Signature: ____________________________



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# Waiver for non-covered service.

Patient's Name: ________________________ Date of Birth: _________________

In order for your Consultation appointment to be paid by Blue Cross insurance, we utilize a New Patient Code for your first Developmental appointment, (code 99205), which allows for less time than a Consultation appointment. For most appointments, additional time is needed with the doctor to get a detailed picture of your child and the issues you are concerned about.

Blue Cross and Blue Shield will not pay for Consultation codes or additional time codes 99354/99355, for prolonged services, for these appointments. They will not pay with an appeal.

***Patients unable or unwilling to pay this portion of the visit will require an additional appointment to be scheduled.***

## BCBS Noncovered Procedure Codes (this is not an inclusive list)

***Prolonged time*** (99354/99355)

CPT code (billing code) 99354/99355, would be applied to your appointment if the time you spend with the doctor at any appointment (excludes ND testing appointments) exceeded the maximum which is allowed by your insurance.

For New Patients- 60 minutes
For patients seen for follow up- no more than 40 minutes is paid by any insurance.

By signing the attached waiver, you are indicating that you understand that you will be responsible for and are willing to pay for this non-covered service which your insurance has determined to be patient responsibility. Payment is due on the date of your consult.

___________________________________ ________________

Signature Parent/Guardian Date



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