GEORGIA AUTISM CENTER
4046 Wetherburn Way, Ste. 1, Peachtree Corners, GA 30092
P: 770-696-4384 F: 770-864-1922

NEURODEVELOPMENTAL HISTORY

This Form is Completely Confidential

Today's date: _____

Client's name: _____
Last **First** **Middle Initial**

Client's date of birth: _____ **Age:** _____ **Gender:** _____

Parent/Legal Guardian's Name(1): _____ **Relationship to Client:** _____
Last **First**

Parent/Legal Guardian's Name(2): _____ **Relationship to Client:** _____
Last **First**

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Parent/Legal Guardian's Employer: _____

Home Phone: _____ **Work Phone:** _____

Cell Phone (Client if adult): _____ **Cell Phone: (Parent 1)** _____ **(Parent 2)** _____

Calls will be discreet, but please indicate any restrictions:_____

May we email info/text appointment reminders? Yes _____ **Email:** _____No _____

Pediatrician or PCP:_____

Phone: _____ **Fax:** _____

Address: _____

Referred by: _____

Person(s) to notify in case of any emergency: _____
Name **Phone**

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so:

(Your Signature): _____

What is the reason for the visit today? _____

_____

_____

Are there previous diagnoses? If so, please list. _____

_____

PRESENTING CONCERNS:

Language Development:

How does your child communicate? (e.g., not speaking, single words, phrases, full sentences, pointing)_____

_____

PLEASE CHECK ALL THAT APPLY: ☐ Overly formal language "little professor" ☐ Echolalia (immediate and delayed) ☐ Jargon after 24 months ☐ Use of "rote" language ☐ Idiosyncratic language (only understood by individual or those familiar) ☐ Neologisms (made up words) ☐ You/I pronoun reversal ☐ Refers to self by name ☐ Repetitive vocalizations (guttural sounds, intonational noise-making, squealing, humming)

PLEASE CHECK ALL THAT APPLY:
Verbal Interaction: ☐ Poor pragmatic/social use of language (not providing clarity or background information) ☐ Failure to respond when name called or when spoken directly to ☐ Does not initiate conversation ☐ One-sided conversation/monologues/tangential speech

Nonverbal Interaction: ☐ Impairments in social use of eye contact ☐ Impairments in the use and understanding of body posture ☐ Impairments in the use and understanding of gesture (pointing, waving, nodding/shaking head, emphatic gesture, descriptive gesture) ☐ Speech atypicalities (volume, pitch, intonation, rate, rhythm, stress, prosody, volume) ☐ Inappropriate emotional expression for the context ☐ Lack of coordinating methods of communication (e.g., not making eye contact and vocalizing/gesturing)

Sensory Concerns:

Do you consider your child to be more sensitive or less sensitive than average in any of the following areas?

	No Concerns	**Highly Sensitive**	**Under Sensitive**
Sights (e.g., bright lights, looking at objects close up)			
Sounds (e.g., vacuum, toilet flush, blender)			
Smells (e.g., foods, perfume, hair)			
Tastes (e.g., textures, mixes)			
Touch (e.g., hair combed/washed, rubbing)			
Clothing textures (e.g., tags, jeans, socks, shoes)			
Intense activities (e.g., jumping, rough play)			
Pain tolerance			

Restricted Interests or Repetitive Behaviors:

How does your child cope with change or with transitions? _____

_____

Please describe any behavioral concerns you have for your child: _____

_____

What tends to trigger your child? _____

_____

How long do tantrums last? _____

Is it easy to calm your child/how are they calmed? _____

Does your child engage in self-injurious behaviors when upset? _____

Have you noticed your child engage in unusual motor movements? **PLEASE CHECK ALL THAT APPLY:**
☐ Repetitive hand movements (clapping, flicking, flapping, twisting) ☐ Complex body movements (foot to foot rocking, spinning) ☐ Abnormalities of posture (toe walking, etc.) ☐ Intense body tensing ☐ Unusual facial grimacing ☐ Excessive teeth grinding ☐ Vocal or motor tics

Have you noticed your child has any unusual attachments to objects/activities, obsessions, or restricted interests? (Please describe.) _____

_____

FAMILY HISTORY:

Parents' names: _____

Parents' relationship status: _____

Siblings/ages: _____

Others residing in the home: _____

Language(s) spoken in the home: _____

Describe the home environment: _____

How do you typically discipline your child(ren) and is it effective? _____

_____

Discuss family stressors that may be contributing to your child(ren)'s difficulties: _____

_____

SOCIAL SUPPORT & SELF-CARE:

Describe your child's personality (outgoing/shy; talkative/quiet; energetic/deliberate): _____

Describe your child's favorite activities:_____

What are your child's strengths?_____

Does your child prefer to play: alone? ___ with one other peer? ___ in a small group? ___ gets along in all settings? ___

How does your child get along with peers? _____

_____

Does your child play in the following ways? **PLEASE CHECK ALL THAT APPLY:**
☐ Nonfunctional play with objects (waving sticks, dropping items, etc.) ☐ Lining up toys or objects ☐ Repetitive opening and closing of toys ☐ Repetitive turning lights on and off ☐ Unusual fascination on parts of toys (i.e., wheels) ☐ Lack of imaginative or creative play

Social Interactions: ☐ Not noticing another's lack of interest ☐ Lack of response to contextual cues ☐ Inappropriate expression of emotion (laughing/smiling out of context etc.) ☐ Unaware of social conventions (such as asking inappropriate questions, making inappropriate statements) ☐ Not noticing another's distress ☐ Not recognizing when not welcome into play or conversation ☐ Limited recognition of social emotions (not noticing when being teased, not noticing how his/her behavior impacts others emotionally)

Does your child seem to understand basic rules of safety (e.g., stranger danger, running into the street)? If not, please describe:

_____

Please briefly describe any self-care concerns (ADLs; hygiene) for your child: _____

_____

How does your child cope with stress? _____

PRENATAL/DEVELOPMENTAL HISTORY:

Is child adopted? Yes _____ No _____ If yes, do you have any involvement with the birth parents? Yes _____ No _____

Please explain contact: _____

Length of pregnancy: _____ Child's weight at birth: _____

Did mother receive prenatal care? Yes _____ No _____ Describe any concerns noted on exams or ultrasounds: _____

_____

Any parental alcohol or substance abuse during pregnancy? Yes _____ No _____ If yes, please describe: _____

_____

Type of delivery (please circle any that apply): vaginal / Caesarian section / forceps / vacuum assist / induced

Other information, if applicable: _____

Child's health at birth: no concerns _____ poor _____ (describe any health problems): _____

_____

Was infant hospitalized for any length of time after birth in neonatal intensive care? Yes _____ No _____

If yes, please describe reasons and length of hospitalization:_____

_____

Give child's age in months for first experiences with:

_____ Response to name _____ Social Smile _____ Toilet trained

_____ Crawling _____ First words _____ Standing Alone

_____ Phrase speech _____ Walking _____Speaking in sentences

Any other developmental concerns? _____

Describe feeding method employed by parents in infancy (breast, bottle, combination): _____

Describe child's eating habits in infancy: _____

Now: _____

Describe child's sleeping habits in infancy: _____

Now: _____

Describe any toileting concerns: _____

INTERVENTION SERVICES/THERAPIES:

Did your child receive early intervention services through Babies Can't Wait? Yes _____ No _____

Has child received ABA, occupational, physical, or speech/language therapy services in the past? Yes _____ No _____

Please briefly describe past services: _____

_____

Is child currently receiving any therapy services (ABA, occupation, physical, speech and language)? Yes _____ No _____

Please briefly describe current services (e.g., type, frequency, who provides services): _____

_____

Has child ever been evaluated by or under the care of a developmental pediatrician? Yes _____ No _____

Name of developmental pediatrician: _____ Date seen: _____

MEDICAL HISTORY:

How frequent are doctor visits now? _____

Please list any allergies: _____

Last hearing and vision exam: _____ Please list concerns noted: _____

Has child had all immunizations to date? Yes _____ No _____

Current Medications: (please list previous medications if you feel is relevant but note no longer taking these)

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations/surgeries (Approximate dates and reasons):_____

_____

_____

Does child have any neurological, chronic or debilitating illness (seizures; diabetes; asthma; etc.)? Yes _____ No _____

Please list: _____

Has child been assessed and/or diagnosed with any genetic/chromosomal issues? Yes _____ No _____

Please list: _____

Has child been evaluated by a neurologist in the past or under the care of one? Yes _____ No _____

Name of neurologist: _____ Phone number: _____

Findings of MRI/CT scans/EEG: _____

Diagnoses: _____

Has child ever sustained any head injuries? Yes _____ No _____ Loss of consciousness? _____

Please describe: _____

Does child have any history of feeding concerns or GI concerns (picky eating, stomach aches, constipation, diarrhea, etc.)?

_____

Does child have a special diet (gluten free, etc.)? _____

Is child followed regularly by any other specialists? Yes _____ No _____

Please describe: _____

MENTAL HEALTH ASSESSMENT HISTORY:

Does your child have difficulties in any of the following areas? **PLEASE CHECK ALL THAT APPLY:**

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety			Aggression			Poor eye contact		
Depression			Withdrawal			Learning problems		
Mood Changes			Opposition-defiance			Self-injurious behaviors		
Anger/Temper			Low self-esteem			Suicidal ideation		
Bed wetting			Poor attachment			History of sexual abuse		
Fears			Often makes careless mistakes			History of physical abuse		
Concentration			Memory problems			Auditory/Visual Hallucinations		
Lack of motivation			Impulsivity			Difficulty completing tasks		
Victim of bullying			Bullying others			Difficulty focusing		
Fidgets frequently			Weight loss			Weight gain		
Hyperactivity			Nightmares			Other:		

Has child ever been evaluated by or under the care of a psychologist? Yes _____ No _____

Name of psychologist: _____ Phone number: _____

Diagnoses: _____

Has child ever been evaluated by or under the care of a psychiatrist? Yes _____ No _____

Name of psychiatrist: _____ Phone number: _____

Diagnoses: _____

Has child ever participated in mental health therapy? Yes _____ No _____ If yes, frequency of visits: _____

Name of therapist: _____ Phone number: _____

Length of treatment and brief description: _____

_____

History of psychiatric hospitalizations (dates/locations): _____

History of suicide attempts: _____

Is there a family history of psychiatric disorders or developmental delays (e.g., autism, ADHD, learning disabilities, etc.)?

If so, please list diagnoses and each individual's relationship to the child: _____

_____

ACADEMIC HISTORY:

Name of school/daycare: _____ Current grade/level: _____

Describe your child's academic performance (average; below average; above average): _____

Has your child ever repeated a grade? Yes _____ No _____ Which grade? _____ Why? _____

Academic strengths: _____ Challenges: _____

What concerns have teachers reported? _____

Any diagnosed learning or academic disabilities? Yes _____ No _____

Please describe: _____

Any participation in resource, special educational (IEP/504; EIP/RTI), or gifted programs? Yes _____ No _____

Please describe: _____

Any current or past participation in any tutoring or learning center programs (e.g. Lindamood-Bell)? Yes _____ No _____

Please describe: _____

Any additional information you would like to include:

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What should I expect for my child's testing appointment?

- After your initial intake appointment, your child will be scheduled to return for comprehensive testing. This appointment will take place with one of the assistants in the office. Assistants are under the supervision of the provider you initially met with and there always is a licensed provider available to assistants for supervision.

- Generally, neurodevelopmental testing is completed in one to two visits, lasting approximately 1-2 hours. If your child is being scheduled for a psychoeducational or neuropsychological assessment, testing could last 2-4 hours or longer, or be scheduled to take place across more than one day. Don't worry though! There will be breaks to allow your child the opportunity to recharge.

- ***Please do not leave the office during your child's appointment***.

- Full payment (if applicable) is expected at the time of testing. Please let us know if you have any questions about this.

- Following your child's testing appointment(s), it takes approximately **6 to 8 weeks** (THIS IS A GUIDELINE) to receive the written report which will be emailed password protected to the email you provided when signing the email waiver. Once the report is provided, we request that you call our office to schedule a follow up appointment to review and discuss the report in depth. Our calendar is busy, but we do everything we can to move parents up on the schedule as we are able. If you make an appointment for several months out, our office will call you with earlier openings as they become available. **Please do not call the office to check on the status of your child's report. Email your child's doctor should you have any questions.**

- Cancellation notice must be provided within 48 hours in advance.

Dr. Jaymie Fox- drjaymie@georgiaautismcenter.com

Dr. April Coleman- drapril@georgiaautismcenter.com

Dr. Ria Travers – drria@georgiaautismcenter.com

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INFORMED CONSENT CHECKLIST FOR TELE-PSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, please agree to the following:

- There are potential benefits and risks of video-conferencing (i.e., limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions (Doxy.me), and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____

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INFORMATION, AUTHORIZATION, AND CONSENT TO TELEMENTAL HEALTH

We are very pleased that you have selected Georgia Autism Center to assist with your child's assessment, and we sincerely look forward to assisting you. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as follows:

"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your child's assessment experience. Please know that you and your child's relationship with us is a collaborative one, and we welcome any questions, comments, or suggestions regarding your child's course of assessment at any time.

TeleMental Health is a relatively new concept, despite the fact that many clinicians have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. We have developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

Telephone via Landline:
It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided us with that phone number, we may contact you on this line from our own landline in our office or from a cell phone, typically only for purposes of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your child's psychologist know. Telephone conversations (other than just setting up appointments) are billed through your child's insurance.

Cell phones:
In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. Telephone conversations (other than just setting up appointments) are billed through your child's insurance.

Video Conferencing (VC):
Video Conferencing is an option for your psychologist to conduct remote sessions with you and you child over the internet where you may speak to one another as well as see one another on a screen. We utilize Doxy.me. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.me is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you and your child's psychologist choose to utilize this technology, your psychologist will give you detailed directions regarding how to log-in securely. We also ask that you please sign on to the platform at least five minutes prior to your session time to ensure you and your child's psychologist get started promptly. Additionally, you are responsible for initiating the connection with your child's psychologist at the time of your appointment.

We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Electronic Transfer of PHI for Certain Credit Card Transactions:
We utilize Merchant One as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card at our facility, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Georgia Autism Center

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

In Case of Technology Failure

During a TeleMental Health session, you and your child's psychologist could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and your child's psychologist has that phone number.

If you and your child's psychologist get disconnected from a video conferencing or chat session, end and restart the session. If you are unable to reconnect within ten minutes, please call your child's psychologist.

Therapist's Office Information: drjaymie@georgiaautismcenter.com; drapril@georgiaautismcenter.com; drria@georgiaautismcenter.com
phone: 770-696-4384

It is important that you are aware of the following prior to consenting to participation in a video conferencing (VC) session regarding your child.

- There are potential benefits and risks of video conferencing (i.e., limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telemental health services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video conferencing platform selected for our virtual sessions (Doxy.me), and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your video conferencing appointment, you must notify the psychologist in advance by email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.

- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- As your psychologist, I may determine that due to certain circumstances, telemental health is no longer appropriate and that we should resume our appointments in-person.

Technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing us to utilize the TeleMental Health methods discussed.

_____ _____

Child's Name (Please Print) **Child's Date of Birth**

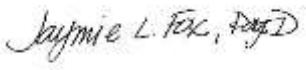
_____ _____

Parent's or Legal Guardian's Name (Please Print) **Today's Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.



_____ _____

Psychologist's Signature **Date**

_____ _____

Psychologist's Signature **Date**

_____ _____

Psychologist's Signature **Date**

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GEORGIA AUTISM CENTER

GEORGIA AUTISM CENTER COMMUNICABLE DISEASE RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT

Due to the 2020 outbreak of the novel Coronavirus (COVID-19), the Georgia Autism Center is taking extra precautions with the care of every client to include health history review and enhanced sanitation/disinfecting procedures and mandating wearing masks in compliance with CDC guidance. Symptoms of COVID-19 include fever, fatigue, dry cough, and difficulty breathing. I agree to the following:

- I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
- I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the past 30 days.
- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the past 30 days.
- I affirm that I, as well as all household members, have not traveled outside of the country or to any city considered to be a "hot spot" for COVID-19 infections within the past 30-days.
- I understand that the Georgia Autism Center cannot be held liable for any exposure to the COVID-19 virus caused by misinformation on this form or the health history provided by each client. The Georgia Autism Center is following the previously mentioned protection procedures amid COVID-19: health history review and enhanced sanitation/disinfecting procedures and mandating wearing masks in compliance with CDC guidance to prevent the spread of COVID-19.

In consideration of being allowed to be treated at GAC, I, the undersigned participant, parent, or legal guardian, acknowledge, appreciate, and agree that:

By receiving services at GAC, there are certain risks to me or my child arising from or related to possible exposure to communicable diseases including, but not limited to, the virus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)", which is responsible for the Coronavirus Disease (also known as COVID-19) and/or any mutation or a variation thereof (collectively referred to as "Communicable Diseases"). I am fully aware of the hazards associated with such Communicable Diseases and knowingly and voluntarily assume full responsibility for any and all risk of personal injury or other loss that I or my child may sustain in connection with such Communicable Diseases.

I, for myself or for my minor child(ren) or ward(s), and on behalf of my/our heirs, assigns, beneficiaries, executors, administrators, personal representatives, and next of kin, HEREBY EXPRESSLY RELEASE, HOLD HARMLESS, AND FOREVER DISCHARGE GAC and its providers, employees, other participants, and, if applicable, owners and lessors of premises upon which GAC related services take place (the "Released Parties"), from any and all claims, demands, suits, causes of action, losses, and liability of any kind whatsoever, whether in law or equity, arising out of or related to any ILLNESS, INJURY, DISABILITY, DEATH, OR OTHER DAMAGES incurred due to or in connection with any Communicable Diseases, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASED PARTIES OR OTHERWISE, to the fullest extent permitted by law.

I agree that this Agreement is intended to be as broad and inclusive as is permitted by the laws of the State of Georgia, and if any portion thereof is held invalid, it is agreed that the remainder shall continue in full legal force and effect.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

_____ _____

Name of Client Client/Parent Signature

_____

Date Signed

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your child's assessment or treatment, and you believe it would be helpful for your psychologist to contact them regarding your child, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your child's treatment or assessment process. Information shared is for the sole purpose of facilitating maximum care to your child. Please provide the necessary information and your signature with today's date as indicated below.

****

I, _____ (parent/guardian), hereby authorize Georgia Autism Center and the following party or parties to discuss my child's neurodevelopmental treatment information and records obtained in the course of treatment or assessment, including, but not limited to, psychologist's diagnosis:

Pediatrician:_____Telephone:_____Fax: _____

Psychiatrist:_____Telephone:_____Fax: _____

Neurologist:_____Telephone:_____Fax:_____

Other:_____Telephone:_____Fax: _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my child's medical and/or neurodevelopmental information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows: _____

____ I DO NOT WANT ANY INFORMATION TO BE RELEASED AT THIS TIME.

Additionally, the above-named parties, therapist/psychologist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above-named therapist/psychologist at 4046 Wetherburn Way, Ste. 1, Peachtree Corners*, GA 30092*. ***This consent to release is valid for one year, or until otherwise specified; and thereafter is invalid. Specify date, event, or condition on which permission will expire: Within 12 months of signed date***

Child's Name: _____ Child's Date of Birth: _____

Parent's/Legal Guardian's Signature: _____ Date: _____

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1) I hereby authorize Georgia Autism Center to use my personal email to send medical information about my child to me. Any HIPAA restrictions relating to medical information transmitted via my free email account are hereby waived.

_____
Child(ren)

_____
Parent/Guardian Circle one Mom Dad Other_____

_____
Email Address

_____
Signature

_____
Date

2) HIPPA and What should I expect for my child's testing appointment?

My signature below indicates that I have read ***HIPPA*** and ***What should I expect for my child's testing appointment?*** *This latter form should be provided to you to bring home.*

_____ _____
Parent's Signature **Date**

READ OUR FULL HIPAA NOTICE OF PRIVACY PRACTICES HERE

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Designation of Another Person to Consent for Care

It is best that children are brought to Georgia Autism Center (GAC) for each visit by a parent or legal guardian. However, there may be times when someone other than you takes care of your child. That person may be a baby-sitter, teacher, or family member. If your child must be seen at GAC at these times, we need a signed consent form to provide medical care.

This consent form allows the person you choose to seek assessment and/or treatment and sign consent for your child when you are unable to come with the child. The person you name must be 18 years of age or older.

How to Use this Consent Form

1. Complete all the information below. Use a separate form for each child.

2. Sign and date the form, and have an adult witness your signature. The person who will accompany your child can be the witness of your signature.

3. Give the completed form to the person you have chosen. Have the person bring the consent form when he or she brings your child to GAC.

4. This Consent for Care is good for one year. It is kept in the child's clinic chart. A new form must be completed and signed every year. There needs to be a different form for each person bringing the child.

I, (parent, legal guardian) _____, cannot accompany my child, _____ (date of birth:_____) to Georgia Autism Center. Therefore, I give permission to (person's name and relationship to child) _____ to seek care and consent for such treatment for my child without having to contact me.

Today's Date _____

(Signature of parent or legal guardian)_____

(**Signature of witness** - 18 years of age or older)_____

GEORGIA AUTISM CENTER
4046 Wetherburn Way, Ste. 1, Peachtree Corners, GA 30092
P: 770-696-4384 F: 770-864-1922

CUSTODY ORDER VERIFICATION

_____ _____
Minor Child Name Child's Date of Birth

__Check here if there is **NO record of any Custody Order** for this patient and sign and date below:

_____ _____
Signature of Parent/Legal Guardian Date

In cases where the client is a minor and the child's parents are separated or divorced or legal guardianship exists, **we require that you furnish us with a photocopy of your complete Custody Order as it relates to your minor child. (There will be a $25 charge to copy your custody order if you arrive without a copy.) The Order must include the custody arrangement and healthcare responsibilities of each party.**

The custody order will provide your doctor with information as to the status of the legal custody of the minor, as well as any specific language that may impact a parent or guardian's right to consent to mental health treatment. Joint Legal Custody can be awarded separate from Joint Physical Custody. Joint Legal Custody means that either parent acting alone may consent to mental health treatment unless the order of Joint Legal Custody has language to the contrary. Orders specifically requiring shared medical decision making responsibilities (barring emergencies) will require the consent of both parents. **If you need help determining your rights to obtain and authorize mental health treatment for your child, please contact your legal representative.**

Your signature certifies that you have read and understand the requirements as they relate to furnishing our office with a copy of your Custody Order and authorizing mental health services for your minor child in the event of separation, divorce or legal guardianship;

___Check here if you have furnished our office with a copy of the child's current Custody Order and sign and date below:

Which parent has primary physical custody and final decision making over psychological/medical treatment?_____

_____ _____
Signature of Parent/Legal Guardian Date

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FINANCIAL POLICY

Thank you for choosing **Georgia Autism Center** for you and/or your child's neurodevelopmental needs. We are committed to providing the best psychological care as possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our financial policy which we ask you to read, initial beside each policy, sign at the bottom of the page and return to us prior to treatment. Please notify your supervising doctor if you have any questions or concerns.

____It is imperative that complete personal information and a copy of your current insurance card is provided prior to being seen to ensure accurate billing. PLEASE NOTE: If incorrect information is given by the patient or patient's guarantor, any denial or unpaid claim will be the financial responsibility of the patient.

____All applicable copays, deductibles, and prior balances are due at the time of service ____We accept cash/checks/credit cards

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Regarding Insurance

_____We participate with most insurance plans. However, you must realize that your insurance is a contract between you and the insurance company and/or your employer. While we may be a provider of services, we are not party to the contract.

_____Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary. In these instances, you will be responsible for these amounts. Some policies have deductibles. If you have a deductible that has not been met, you will be responsible for payment at the time of the service.

_____Please be aware that insurance companies usually require a co-payment or co-insurance to be collected for every visit with a provider, whether it is a doctor or doctor's assistant.

_____Our office can NEVER guarantee coverage for any service provided because insurance companies will not guarantee benefits until they receive the claim for services. It is important that you educate yourself about your individual insurance benefits. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

Missed Appointments

____Please help us serve you better by keeping scheduled appointments. Appointments must be cancelled at least 48 hours in advance. Please be aware that if you no-show for your appointment, or cancel your appointment within 24 hours of your scheduled appointment, you will be charged a $60.00 fee. Repeated cancellations or no-shows may preclude you from scheduling future appointments.

Past Due Accounts

_____Overdue accounts will be turned over to a collection agency. Please be aware that a $50.00 processing/filing fee as well as a fee of 40% of your balance will be added to your account. Example: $200 owed + $50.00 processing + $80.00 (40%) = $330 will be your new account balance.

_____Records, including completed evaluations, may not be released if there is an unpaid balance.

Returned Checks

____For checks returned to use as unpaid by your bank, we will charge a $45 fee.

Requesting forms to be completed by provider

____Additional forms to be completed by your provider will be subject to a $60 fee (i.e., FMLA, Service dog)

I have read the Financial Policy. I understand and agree to the Financial Policy:

_____ _____ _____

Print Name Signature Date

_____

Child's name (if applicable)