DEVELOPMENTAL-BEHAVIORAL PEDIATRICS

Dear Parent(s) or Guardian(s),

We appreciate your child's referral to the Division of Developmental-Behavioral Pediatrics of the Greenville Hospital System University Medical Group. Enclosed you will find a packet of information for you to complete to help our clinicians fully evaluate your child.

These forms include:

- Parent Questionnaire
- Request for Medical Information. If your child sees more than one physician or is receiving counseling, please leave the provider name blank and include a list of all providers your child sees on a separate page
- New patient information forms and financial agreements

You'll also find a list of school records that we request (if your child attends school). These records will help us to ensure a complete and thorough evaluation.

Please complete and return each of these forms to our office. Once we've received them, our clinicians will be able to determine what type of evaluation will best meet your child's needs. **The entire packet must be returned before an appointment can be scheduled for your child.** Our scheduling office will then contact you when there is an appointment available for him/her.

Unfortunately, due to the increasingly large number of referrals our division receives each month, families often have to wait several months for an appointment. Our department is currently trying to hire additional clinicians and implementing programs in order to reduce the amount of time newly-referred families have to wait. We apologize for the inconvenience and will continue to work to decrease the wait time for an appointment. If we are able to identify other services that may be beneficial, we will notify you with this information so that your child can receive services as soon as possible.

If the concern is resolved before your child is scheduled for an appointment, please contact our office at (864) 454-5115 so that he/she may be removed from the waiting list.

Thank you,

The Division of Developmental-Behavioral Pediatrics
Greenville Hospital System University Medical Group

Children's Hospital
Greenville Health System

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
PATIENT INFORMATION

PATIENT INFORMATION (Please print)

Full Legal Name: ____
Last *First* *Middle*

*Preferred Name:*________________ Sex: ○ Male ○ Female Date of Birth:__________

SS#:____________ Primary Care Physician:______________________________

Race: ○ *Caucasian (white)* ○ *American Indian* ○ *African American (black)* ○ *Hispanic*
○ *Biracial* ○ *Asian Oriental* ○ *Other* ○ *Unknown*
○

Home Address:______________________ City__________________State_____Zip________

Mail to Address:______________________ City__________________ State_____Zip________
(If Different)
County: ____

Primary Phone:(   )___________________Secondary Phone:(   )______________________

EMERGENCY CONTACT (Pediatric Patients please list someone other than parent(s)/guardian)

Name:____________________________ Relation to Patient:_________________________

Primary Phone: (   )______________________ Secondary Phone: (   )_________________

PRIMARY INSURANCE INFORMATION
What type of primary insurance does the patient have?______________________________
ID#______________________________________

SECONDARY INSURANCE INFORMATION
What type of secondary insurance does the patient have?____________________________
ID#______________________________________

Name of person completing form:____

Are you the patient's natural parent? ○ Yes ○ No
If no, please select one of the following:
○ Foster Parent ○ Adoptive parent ○ Temporary Guardian

*****Please note that if you are not the natural parent, proper paperwork is required before the first visit *****

Signature of
Patient/Guardian:____ Date:___________

Developmental-Behavioral Pediatrics
200 Patewood Drive Suite A200, Greenville SC 29615
Phone: 864-454-5115 Fax: 864-241-9205

Children's Hospital
Greenville Health System

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ONE PER REQUEST

Patient Full Name (PRINT)______________________________ SS# ________________ DOB____________

Is requesting that the Greenville Hospital System University Medical Group practice identified above release health information (check one) ☐ TO or obtain ☐ FROM the person/company/agency/facility listed below.

Name, Position, or Department:	
Name of Organization:	
Address of Organization:	
Phone number of Organization:	

The information to be disclosed relates to service dates beginning ______________ and ending ______________

☐ Entire medical record *	☐ Medication List	☐ Physical Therapy notes
☐ Demographic Information	☐ Immunizations	☐ Occupational Health Record
☐ History & Physical	☐ Test Results (lab, X-ray, etc.)	☐ Psychological/Neuropsychological Evaluation results
☐ Medical/Surgical History	☐ Other Assessments	
☐ Physician Office Visits	☐ Discharge Summary	☐ Other: (specify)

*Psychotherapy notes are excluded from release

The purpose of the disclosure: *("Request of the Individual" is sufficient for patient-initiated releases)*

☐ Request of Individual	☐ Change of Doctor	☐ Legal Investigation
☐ Referral to Specialist	☐ Insurance	☐ Other: (specify)
☐ Continuing Care	☐ Workers Comp	

CONDITIONS and NOTIFICATIONS:

This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the GHS UMG group practice identified above and to GHS and each practice and entity affiliated with it including GHS Partners in Health.

Note: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

SIGNATURES:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: ________________________________ Date: ______________

PRINT Name of Personal Representative: ____

Relationship of Representative to Patient: ____

Released by: ____ Date: ______________
(Department Representative Name/Title)

11-20-07

SCHOOL RECORDS REQUESTED

Below you'll find a list of school records that we request to help us ensure a thorough and efficient examination of your child. If your child attends school, please send us all of the following records that apply.

If your child has not had these evaluations done, then you do not need to do anything further. If your child has had these evaluations completed and you do not have these records already, please request them from the school.

School Records Needed:

- Any psychological or psycho educational testing
- Individual Education Plan (IEP)
- 504 Accommodation Plan
- Other evaluations such as speech, occupational or physical therapy
- Standardized Achievement Testing
- Any communication from teacher specific to problem (disciplinary reports, report cards, etc.)

Please mail these records to:

Developmental-Behavioral Pediatrics
Scheduling Department
200 Patewood Drive; Suite A200
Greenville, SC 29615

Or fax to: 864-241-9205

Division of Developmental-Behavioral Pediatrics
200 Patewood Drive, Suite 200A
Greenville, SC 29615
454-5115

Policy for Missed Appointment ("No-Show")

Effective Date November 1, 2007

Patient Name: DOB:

In order to better address the needs of our patients, the Division of Developmental-Behavioral Pediatrics monitors and logs all scheduled appointments that are missed or not cancelled prior to the appointment time. We ask that you provide a 24-hour notice of cancellation if possible.

You may notify our office of any cancellation by calling 454-5115 (Children's Hospital Outpatient Center at Patewood, or Spartanburg location) or 331-1349 (Center for Developmental Services location) between the hours of 8:30 a.m. and 4:30 p.m. Monday- Thursday and 8:30 a.m. and 3:30 p.m. Friday. The answering service is available in order to leave a message during those hours the office is closed.

If two appointments are missed with no notification, you will receive a discharge letter and will be terminated from the practice.

I have read, understand, and agree to abide by the above policy.

Patient/ Guardian Signature Date:

NS form 1/08

CHILDREN'S HOSPITAL OUTPATIENT CENTER
DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
FINANCIAL CONSENT FORM

Patient Name:______________________________ **Date of Birth:** __________________

Your child has been referred for an evaluation through Developmental-Behavioral Pediatrics. Specific evaluations are determined based upon the child's individual needs. Listed below are the types of evaluations that could be scheduled for your child and an **estimate of the charges**. Unless otherwise noted, all charges will be submitted to your insurance company. Your insurance company will only pay for services that are covered under the benefits stated in your policy and that they have determined to be medically necessary. Based on your benefits, co-payments and co-insurance may apply.

______ Initial Consultation-CPT Codes: 99241-99245($106-$530)
Developmental Physician or Nurse Practitioner

______Developmental Testing- CPT Codes: 96111 ($275-350 per hour); 96110 ($30-40 per assessment)
Developmental Physician or Nurse Practitioner

______Follow-Up- CPT Codes: 99211-99215 ($42-$290)
Developmental Physician or Nurse Practitioner

______Extended Time CPT Codes: 99354($210 1st hr) and 99355($209 each add'l 30 min)
Developmental Physician or Nurse Practitioner

______Psychology/Neuropsychological Diagnostic Interview- CPT Code 90801($340-370)

______ Psychological/Neuropsychological Testing $210-240 per unit of testing
(5 to 8 units are average; units include face to face assessment, scoring, interpretation, and report generation) CPT Code- 96101, 96118

______ Individual Therapy with Psychologist- CPT Code 90806 ($240)

______ Family Therapy with Psychologist- CPT Code 90847 ($210)

The Developmental Physician and Nurse Practitioner price ranges depend on the amount of time spent with the patient and/or the amount of time spent performing, interpreting, and reporting evaluations.

Other evaluations may be requested with other divisions at Children's Hospital. These evaluations will be billed by the division in which they take place. Please contact those divisions if you have any questions about those charges

I have read the above information about evaluation costs and insurance coverage. In the event my insurance company denies coverage under the conditions of my policy, I understand that I will be and agree to be personally and fully responsible for payment.

______________________________ __________________
Parent/Guardian Signature Date

Patient ______________________ DOB ________________

Because of the nature of your child's appointment, your insurance company may have restrictions in place based on the type of service we provide or more specifically the diagnosis your child receives. Before you come in for your child's appointment, please call your insurance company. Below is a list of questions to help you when speaking to the insurance representative.

1. Does my policy cover specialty pediatricians?
2. Does my policy cover diagnosis such as Autism, ADHD, Learning disabilities, dyslexia, developmental delays, or speech issues?
3. Does my policy cover Developmental testing codes including 96111, 96110, and 96116 under my medical plan?
4. If my child is seeing a psychologist: Do I have mental health benefits? If so, who administers my mental health benefits?

By signing below, I am verifying that I have spoken with my insurance company and do understand my benefits as they pertain to my visit with University Medical Group Developmental Pediatrics. I understand that if my insurance company does not cover the services, I will be responsible for any balances. If you have any questions, please feel free to call Carrie Christy at 797-6263 or Michelle Long at 797-6377.

____

Signature of Parent

____

Date