Thank you for your interest in the services provided at Schmieding Developmental Center (SDC) a program of the University of Arkansas for Medical Sciences, College of Medicine, Department of Pediatrics.

SDC recently received a referral from your child's primary care provider &/or medical specialist. In order to best meet the needs of your child, please complete and return the included Patient Information Packet to SDC at your earliest convenience. Incomplete Patient Information Packets will delay processing. Once the completed packet has been received, the triage team will review and request additional information as needed.

> *If your child has been previously evaluated for developmental and/or behavioral concerns (i.e., speech therapy, psychoeducational/developmental or psychiatric evaluations, etc.) and you have copies of any of their reports, please mail/fax them to our clinic along with this form.

When all information has been obtained a clinician will review and determine if a comprehensive evaluation is warranted. Once the need for an evaluation has been determined an appointment can be scheduled. Unfortunately, due to the specialized services we provide and the large number of referrals that SDC receives, families often have to wait several months for an appointment. If a comprehensive evaluation is not warranted, you and the referring physician will receive notification with recommendations indicating what services would best meet the needs of your child.

SDC accepts Arkansas Medicaid and most private insurances.

If you have any changes to your contact information before your appointment, please contact our office to update your record. Two days prior to your appointment you will receive a phone call to confirm the appointment. If SDC is unable to obtain a verbal confirmation, your appointment will be cancelled.

Please mail your completed Patient Information Packet with the requested information to our clinic within 3 weeks of receiving it (if completed packet is not received within the time allotted, referral will be discharged and PCP will be notified):

Mailing Address
SDC: New Patient Packet
519 Latham Drive
Lowell, AR 72745

If you have questions or concerns, please contact SDC at 479-750-0125 press option 1 then option 2 to talk to a staff member or email us at sdc@uams.edu. We look forward to working with you and your child.

Sincerely,

Mary Ann Scott, Ph.D.

Mary Ann Scott, Ph.D.
Pediatric Neuropsychologist
SDC Administrative Director
(ELECTRONIC SIGNATURE ATTACHED)

Patient Name: _____ Date of Birth: _____

## CONSENT FOR TESTING, EVALUATION AND TREATMENT

I consent to medical care and treatment for the patient named above at the UAMS Schmieding Developmental Center. I understand and agree that the practice of medicine is not an exact science and there is no guarantee any particular treatment will be successful. I understand that this facility is part of a teaching facility and agree that medical students, residents and others in training programs may be involved in my care and treatment under the supervision of a qualified professional. I understand that I have the right to consent or refuse any proposed procedure or treatment.

## ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

In consideration of services rendered, I hereby assign any benefits due under my insurance coverage to Children's University Medical Group ("CUMG"). I understand that I am financially responsible for all charges not covered including deductibles, co-pays, and co-insurance. After reasonable notice, accounts not paid may be turned over to a collection agency and/or attorney, and I understand I will be responsible for any related attorney's fees, costs of collection and court costs. I understand it is my responsibility to comply with all pre-authorization requirements of any insurance or medical/hospital coverage plan that is relied on for coverage. I agree that CUMG, their designated collection agency, attorney or other authorized designee on behalf of CUMG may contact me on my cell phone, land line or any other number I provide, directly, through an automated dialing system or through an artificial or prerecorded voice system to discuss payment of any unpaid financial obligation I have at CUMG or to receive general information and this consent shall remain valid until expressly revoked.

## RELEASE OF INFORMATION AUTHORIZATION

I understand my protected health information will be released in accordance with the UAMS Notice of Privacy Practices. I acknowledge that I have received a copy of the UAMS Notice of Privacy Practices on this or a prior occasion.

We respect the privacy of your health information. If you wish to grant permission for us to share your medical or billing information with a family member or friend involved in your care, who is not otherwise authorized by law to act on your behalf, please specify below. You are not required to grant this permission and may revoke this permission at any time by contacting our office at 479-750-0125 or the UAMS HIPAA Office at 501-603-1379.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

SIGNATURE_____ DATE_____

Patient or Adult Legally Responsible for Minor Child Patient

**Please note, items marked by an "*" are used for statistical purposes only and will not affect your application.**

PATIENT and GUARANTOR INFORMATION:
Child's Name_____ Birth Date_____
Age_____ *Sex_____ *Race_____ Primary Language_____ Social Security #_____

Medicaid Policy #_____ Insurance Co._____ Benefits Phone Number_____
Policy #_____ Group #_____
Subscriber_____ Relationship to Patient_____

Guarantor's Name_____ Relationship to Patient_____
(Person responsible for payment)
Social Security #_____ Birth Date_____ Employer_____
Home Phone #_____ Work Phone #_____ Cell Phone #_____ E-Mail_____
Guarantor's Address_____
P. O. Box or Street

_____
City State Zip Code County

Legal Guardian's Name _____ Relationship_____
Home Phone #_____ Work Phone #_____ Cell Phone #_____ E-Mail_____
Guardian's Address_____
P. O. Box or Street

_____
City State Zip Code County

EMERGENCY INFORMATION:
Nearest Relative_____ Relationship_____ Phone_____
Primary Physician_____ Phone_____

**By providing your email address and signing below, you are agreeing that we may send medical related correspondence to you via email. You may withdraw your consent to email correspondence at any time by notifying a member of our office staff**

**Please fill out this form as completely as possible. This information is necessary to determine your child's accurate diagnosis and how best to serve your child needs.**

Who referred you to this clinic?
Name_____ Relationship_____ Phone #_____

**PARENT'S or CAREGIVER'S CONCERNS:**
What are your current concerns? _____
_____
_____

What have you been told by doctors, teachers, and/or others about your child's problem? _____
_____
_____

What do you expect or hope to have happen as a result of an evaluation at the Schmieding Developmental Center?
_____
_____

**PREGNANCY/BIRTH HISTORY:**

Name of hospital your child was born at: _____ City and State of Hospital: _____

Mother's age at time of birth: _____ Month prenatal care began: _____

Amount of cigarettes smoked: _____ Months smoked: _____

Amount of alcohol consumed: _____ Months drinking done: _____

Medications or Drugs taken: _____ Months/Problems: _____

(other than vitamins & iron) _____ Months/Problems: _____

_____ Months/Problems: _____

Illness during pregnancy: _____ Months/Problems: _____

_____ Months/Problems: _____

_____ Months/Problems: _____

Length of pregnancy:_____ Length of labor: _____ Was labor induced? ☐ NO ☐ YES

Birth was: Normal (vaginal) _____ Cesarean _____ Breech _____ Twins or more _____

Were forceps used? ☐ NO ☐ YES Mother's complications (if any)? _____

Birth weight: _____ Apgar Scores:_____ How long before the baby breathed without help? _____

How long did baby stay on a ventilator? _____ Why? _____

How long did baby stay in the hospital after birth? _____ Why? _____

Was the baby transferred to another hospital after birth? ☐ NO ☐ YES Where? _____

Was baby jaundiced? ☐ NO ☐ YES If yes, what kind and how long was treatment? _____

Describe any other complications or problems: _____

_____

_____

**CHILD'S DEVELOPMENTAL & MEDICAL HISTORY:**

**Medical:**

Check any of the following which pertain to your child, indicating age and complications:

| | Age | Complications | | Age | Complications |
|---|---|---|---|---|---|
| ☐ Ear Infections | _____ | _____ | ☐ Headaches | _____ | _____ |
| ☐ Fainting Spells | _____ | _____ | ☐ Accidents | _____ | _____ |
| ☐ Frequent Falls | _____ | _____ | ☐ Thyroid Problems | _____ | _____ |
| ☐ Strep Infections | _____ | _____ | ☐ Visual Problems | _____ | _____ |
| ☐ Diabetes/Hypoglycemia | _____ | _____ | ☐ Hearing Problems | _____ | _____ |
| ☐ Meningitis | _____ | _____ | ☐ PE Tubes | _____ | _____ |
| ☐ Seizures | _____ | _____ | ☐ Other | _____ | _____ |

Has your child ever been hospitalized for surgery or other problems? ☐ NO ☐ YES If yes, then:

When? Why? Where? (name and city of hospital)

_____

_____

_____

_____

Has your child been seriously sick, injured, or exposed to toxins or violence, but not hospitalized: ☐ NO ☐ YES

If yes, when, how, or with what? _____

_____

_____

Does your child have any allergies (to medicines, foods, animals, etc.)? ☐ NO ☐ YES

If yes, to what and how does it affect him/her? _____

_____

_____

List all medications your child currently takes or has taken for long periods of time in the past:

| MEDICINE | AMOUNT | REASON | WHEN TAKEN |
|---|---|---|---|

_____

_____

_____

_____

_____

Are you certain your child has all the necessary immunizations to keep him/her safe? ☐ NO ☐ YES

If no, then where do you get immunizations and what is missing? _____

_____

What medical tests (like x-rays, EEG, blood tests, etc.) has your child had done in the past? ☐ NONE

What test? When done? What result?

_____

_____

_____

**Growth & Development:**

Motor Skills: At what age did your child…? (write "not yet" where appropriate)

Smile _____ Roll Over _____ Sit without support _____ Hold a cup _____

Crawl _____ Pull to Stand _____ Walk Alone _____ Hold a pencil _____

Pedal a Tricycle _____ a bicycle _____ Hold a pencil correctly _____

What concerns, if any, do you have about your child's motor development? _____

_____

Language and Hearing: What age did your child…? (write "not yet" where appropriate)

Make single sounds _____ Use words _____ Combine words into short sentences _____

Does your child communicate mostly by: ☐ words ☐ crying ☐ phrases ☐ sentences OR

☐ gestures (like pointing, pushing, pulling, shrugging shoulders, nodding head, etc.)

Did your child begin to use words and then stop? ☐ NO ☐ YES Stopped at what age? _____

What concerns, if any, do you have about your child's speech, language, or hearing? _____

_____

_____

Feeding: (write "not yet" where appropriate)

Was your child bottle fed? ☐ NO ☐ YES Breast milk fed? ☐ NO ☐ YES History of Reflux? ☐ NO ☐ YES

Did your child have changes in formula? ☐ NO ☐ YES If yes, why: _____

For his/her age, is your child: ☐ average ☐ underweight ☐ overweight

For his/her age, is your child: ☐ average ☐ too short ☐ too tall

Has your child had any problems with: ☐ feeding ☐ chewing ☐ teeth ☐ swallowing

What eating problems or unusual food habits does your child have? _____

_____

_____

Personal/Social: At what age did your child? (write "not yet" where appropriate)

Give up the bottle _____ Feed him/herself _____ Bladder train _____

Drink from a cup _____ Dress him/herself _____ Bowel train _____

Any problems with interaction and relations with other children or adults? _____

_____

_____

Temperament, Emotion, and Behavior: (What kind of person was and is your child: easy/hard, sensitive/tolerant, quiet/loud, shy/outgoing, active/passive, happy/unhappy, etc. Describe any emotional or behavior problems that you or others see.)

As an infant: _____

As a toddler: _____

Preschool child: _____

Elementary: _____

High School: _____

Sleep Habits:

As an infant: _____

As a toddler: _____

Preschool: _____

Elementary: _____

High School: _____

**FAMILY MEDICAL/DEVELOPMENTAL HISTORY:**

**Biological Father's Name** _____ Date of Birth _____
First Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other Vocational Training _____

Gross Annual Income* _____ Home Phone #_____Cell # _____

**Biological Mother's Name** _____ Date of Birth _____
First Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other Vocational Training _____

Gross Annual Income* _____ Home Phone #_____Cell # _____

Is the child Adopted? ☐ NO ☐ YES If so please fill out the following information:

Age at Adoption_____ Is the child aware he/she is adopted? ☐ NO ☐ YES

**Adoptive-Father/Guardian**_____ Date of Birth _____
First Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other Vocational Training _____

Gross Annual Income* _____ Home Phone #_____Cell # _____

**Adoptive-Mother/Guardian**_____ Date of Birth _____
First Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other Vocational Training _____

Gross Annual Income* _____ Home Phone #_____Cell # _____

Marital status of parents _____ Date divorced, if applicable _____

Date of death of parent, if applicable _____ Which parent? _____

How long has the family lived at the current address? _____

Where else has the family lived during the child's life? _____

_____

_____

Indicate recent family stressors (financial concerns, births, deaths, marital conflicts, etc.): _____

_____

_____

Indicate any Department of Human Services or other social service involvement: _____

_____

_____

List all persons living in the home:

| NAME | AGE | RELATIONSHIP TO CHILD |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Family Interactions (How do you get along? How do you discipline? What family activities? etc.): _____

_____

_____

Please note below if any of the child's relatives (parent, brother, sister, aunt, cousin, etc.) have had any of the following conditions:

| | Relationship to Child | | Relationship to Child |
|---|---|---|---|
| Convulsions (seizures) | _____ | Learning Problems | _____ |
| Cerebral Palsy | _____ | Attention Problems | _____ |
| Muscle Weakness | _____ | Speech Problems | _____ |
| Muscle Tics (twitches) | _____ | Vision Problems | _____ |
| Tourette's Syndrome | _____ | Hearing Loss | _____ |
| Headache (migraine) | _____ | Intellectual Deficiency | _____ |
| Tuberculosis | _____ | Hyperactivity | _____ |
| Hepatitis | _____ | Autism | _____ |
| HIV (Aids) | _____ | Anxiety | _____ |
| Skin Disease | _____ | Depression | _____ |
| Kidney Disease | _____ | Other Mental Health Issues | _____ |
| Bone Disease | _____ | Legal Trouble (jail) | _____ |
| Stroke | _____ | Drug Addiction | _____ |
| Cancer | _____ | Alcoholism | _____ |
| Thyroid | _____ | Violence | _____ |
| Diabetes | _____ | Other | _____ |

Describe any of the above: _____

_____

_____

Siblings: Complete the following table for all of the mother's pregnancies beginning with the first (including any miscarriages or stillbirths).

| Year of Pregnancy | Father's Last Name | Length of Pregnancy | Length of Labor | Problems at Birth | Any physical, emotional, behavioral, or educational problems? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Siblings: Father's children by other unions:

| Year of Pregnancy | Mother's Full Name | Length of Pregnancy | Length of Labor | Problems at Birth | Any physical, emotional, behavioral, or educational problems? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**SCHOOL HISTORY:**

**Please bring all old report cards, school achievement, and other testing results that you can find or get from the schools.**

Preschool: Did your child attend a program or day treatment program? ☐ NO ☐ YES

If yes, where and for how long:_____

_____

Home School: Is your child Home Schooled? ☐ NO ☐ YES If yes, what curriculum is used: _____

Kindergarten: Age began _____ Any Problems _____

School Age:

List all schools attended:

Name of School Grades Attended Dates Attended

_____

_____

_____

_____

_____

Has your child repeated a grade(s) or been held back: ☐ NO ☐ YES

If yes, which grade and why:_____

List extra-curricular, sport, or club activities of child: _____

_____

_____

Is your child currently receiving additional services through the school? ☐ NO ☐ YES

☐ Self-contained special education ☐ Resource ☐ Remedial/Chapter 1

☐ Speech/language therapy ☐ Occupational therapy (OT) ☐ Physical Therapy

☐ ABA Therapy ☐ School Based Therapy ☐ Other, please specify: _____

Date of last school testing: _____ Results of testing: _____

(Attach copies of testing if possible.)

Have you requested testing from the school? ☐ NO ☐ YES

Is any testing scheduled? ☐ NO ☐ YES If yes, when? _____

_____

Are you satisfied with your child's placement? ☐ NO ☐ YES If no, why? _____

_____

_____

What do you feel is your child's main problem at school? _____

_____

_____

What do you feel the school thinks is your child's main problem? _____

_____

**PLEASE LIST THE NAMES AND ADDRESSES OF OTHER PROFESSIONALS WHO HAVE WORKED WITH YOUR CHILD BELOW AND ALSO ON YOUR AUTHORIZATION TO RELEASE INFORMATION FORMS** *(INCLUDED IN PACKET)*:

| | NAME | PHONE |
|---|---|---|
| Pediatrician | _____ | |
| Occupational Therapist | _____ | |
| Speech Pathologist | _____ | |
| Physical Therapist | _____ | |
| Health Department (Nurse) | _____ | |
| Mental Health Professional | _____ | |
| Specialist (please specify) | _____ | |
| Other (please specify) | _____ | |

I certify that the information I have provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Patient or Adult Legally Responsible for Minor Child Patient

*Please make sure to include a copy of the front and back of your insurance card(s) with this packet. You can also email a picture of the card to sdc@uams.edu, please make sure you include the child's name and date of birth on the email.

# AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, _____, hereby authorize Schmieding Developmental Center to release/request medical records, to include verbal and electronic communication, to/from the following individuals/clinics/hospitals:

PCP: _____ Phone: _____

ENT: _____ Phone: _____

Vision: _____ Phone: _____

Neurology: _____ Phone: _____

Genetics: _____ Phone: _____

Birth Hospital: _____ Phone: _____

Mental Health: _____ Phone: _____

ST, OT, PT: _____ Phone: _____

Other: _____ Phone: _____

Please list persons that may receive information (verbal or written) on behalf of your child.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Information of:
Patient Name: _____ DOB: _____

The purpose of this authorization is for <u>treatment</u> or: _____ Payment _____ Other: _____

The purpose of this disclosure is for evaluating &/or treatment. I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire _____ (date) OR 1 year from date signed.

The facility, its employees, and clinicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations. I agree to pay the cost of copying, supplies, labor, postage, and other expenses associated with the request as allowed by law.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

_____ _____ _____

Legal Representative Signature Relationship Date

UAMS | Schmieding Developmental Center

# AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, _____, hereby authorize Schmieding Developmental Center to release/request information, to include verbal and electronic communication, to/from:

School District/Name: _____

Address: _____ _____
*Street Address* *City* *State* *Zip*

Phone: _____ Fax: _____

Information of:
Patient Name: _____ DOB: _____

The purpose of this authorization is for <u>treatment</u> or: _____ Payment _____ Other: _____

All records including but not limited to:

- School Report
- Reports Card History
- Language Proficiency Testing
- Developmental/Psycho Ed Evaluation
- 504 Plan
- Behavior Evaluation/Plan
- Physical Therapy Evaluation
- Medication Management
- Teacher Rating Form
- Achievement Test (Benchmark)
- MAC &/or ELDA Scores
- IFSP/IPP/IEP
- RTI / IRI Plan
- Speech Evaluation
- Occupational Therapy Evaluation
- Health Plan

☐ Other: _____

I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire _____ (date) OR 1 year from date signed.

The facility, its employees, and clinicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations. I agree to pay the cost of copying, supplies, labor, postage, and other expenses associated with the request as allowed by law.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

_____ _____ _____
Legal Representative Signature Relationship Date