



**FOR DEVELOPMENTAL EVALUATIONS: PLEASE PRINT**

Child's Name: \_\_\_\_\_ M F Birth date: \_\_\_\_\_ Student Status: FT PT N/A  
(First) (Last)

Child's Social Security #: \_\_\_\_\_ Who does the child live with? \_\_\_\_\_

Primary Care Physician: **if not in this office.** \_\_\_\_\_ Tel. No.: \_\_\_\_\_ Fax. No.: \_\_\_\_\_

**SIBLINGS:**

Name: \_\_\_\_\_ SocSec#: \_\_\_\_\_ M F Birthdate: \_\_\_\_\_

Pharmacy Name & Tel. No.: \_\_\_\_\_ Who referred you to this practice? \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION: Single Married Divorced Separated Widowed Partnered with ( Please circle )**

Father/Parent/ Guardian's name: \_\_\_\_\_ Mother/Parent/Guardian's name: \_\_\_\_\_  
(First) (Last) (First) (Last)

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SocSec#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SocSec#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_ Email address: \_\_\_\_\_

Profession/Employer: \_\_\_\_\_ Profession/Employer: \_\_\_\_\_

**Insurance Information ( Please present your insurance cards to the receptionist at every visit )**

**First Insurance:** \_\_\_\_\_ **Second Insurance: I do not have a secondary insurance:** \_\_\_\_\_  
Initial

Name of Insurance Co: \_\_\_\_\_ Name of Insurance Co: \_\_\_\_\_

ID#: \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Soc Sec #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship to Insured: Child Stepchild Other \_\_\_\_\_ Relationship to Insured: Child Stepchild Other \_\_\_\_\_

**ASSIGNMENT AND RELEASE AND AUTHORIZATION FOR CARE OF MINOR**

I, the undersigned, assign directly to Pediatric Associates of Farmington, L.L.C. all medical benefits, if any, otherwise payable to me for services rendered to my child(ren). I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I give permission for the staff of Pediatric Associates of Farmington, L.L.C. and the clinical providers and their staff, to provide any necessary medical care to my minor charge(s) listed above.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ **PLEASE TURN OVER**



**PLEASE PRINT**

**PERMISSION**

Please consider this a request for me to exercise my rights under Federal and State laws by requesting only the following people to communicate in every way any confidential communication about my child's protected health information (PHI) with the provider and / or staff when the legal guardian(s) are not present. I understand that the providers and staff will need to treat the child as if I was present and the PHI may be disclosed during these appointments. I will be contacted as necessary. This form remains in effect as long as I do not make any changes.

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PRIVACY PEDIATRIC ASSOCIATES OF FARMINGTON, LLC**

**Names of all children that apply to these restrictions:**  All the children listed on the first page.

Patient Name \_\_\_\_\_ Patient Name \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient Name \_\_\_\_\_

**RESTRICTIONS QUESTIONNAIRE**

May we send statements and reminder cards to the address in the Registration sheet?	Yes	No
If no, what address should be used? _____		
May we contact you at work?	Yes	No
May we contact you at home or on the cell phone?	Yes	No
If not to both of the above, which number should we call? _____		
May we leave messages (including laboratory results) on your answering machine?	Yes	No
May we send you a fax? If yes, Fax No. _____	Yes	No
	Yes	No
May we contact you via email? If yes, Email address _____		

\_\_\_\_\_  
Name of Patient or Legal Representative                      Signature                      Date

**For the Staff only : \_\_\_\_\_ To be completed only if unable to obtain written acknowledgement from patient:**

On \_\_\_\_\_, Pediatric Associates of Farmington, LLC attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-name patient. We were unable to obtain this acknowledgement because:

Patient declined to sign this written acknowledgement.  Patient did not understand the request to sign the written acknowledgement  
Other (please specify) \_\_\_\_\_

\_\_\_\_\_  
Signature & Date of Employee                      Signature & Date of Witness

For restrictions to your protected health information (PHI) other than noted above, please submit your request to the Compliance/Privacy Officer utilizing our "Restriction of Use or Disclosure of Protected Health Information (PHI) Form."



**PLEASE PRINT**

**To make it easier for the providers to concentrate on the care of your child we ask you to review these policies and cooperate with us in ensuring the best care for your child.**

Thank you for understanding and please let us know if you have any questions

1. **AT EVERY VISIT:** Please bring the patient's insurance card, your photo-ID and any payment/co-pay applicable at each visit.  
**Federal trade commission identity theft: 'RED FLAGS RULE': We have to check photo identification at every office visit to comply with this rule.**
2. **APPOINTMENTS:** please make your next physical exam or follow up appointment before you leave.
3. **CALL REMINDERS:** A courtesy call is given prior to the appointment but we expect the caregivers to make note of their appointments.
4. **FAILURE TO KEEP APPOINTMENTS:**
  - a. A fee of \$100 will be charged for any missed appointments or for failure to cancel the appointment 24 hours prior to the appointment.
  - b. We shall be unable to schedule any more appointments if either the initial appointment or more than three appointments are missed.
5. **CO-PAYS:** All payments are expected at the time of the visit. We will be charging an administrative fee of \$5.00 if asked to bill.
6. **RETURNED CHECKS:** A fee of \$25.00 will be charged for every returned check.
7. **PRESCRIPTION REFILLS AND FORMS:** Please give us 24-48 hours. Forms not requested at the annual physical exam will be charged an administrative fee of \$5.00 each.
8. **ACCOMPANYING CHILDREN:** Please let us know when you come, if the accompanying child(ren) also need(s) to be seen so we can inform you if it is possible without inconveniencing the next patient.
9. **ELECTRONIC DEVICES:** Please do not use any electronic devices while in the office. Our patients and providers need your full attention and we request all to respect that.

**The policies written above have been reviewed and understood.**

**Signature and name of legal guardian of the child(ren) listed on registration sheet: \_\_\_\_\_**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**DEVELOPMENTAL EVALUATION APPLICATION FORM**

Child's Name: \_\_\_\_\_ M / F Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Last First Name (Any Other Name)

**Why do you want this child evaluated? Please list all the concerns.**

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When were these problems first noted and by whom? \_\_\_\_\_

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What has prompted you to seek evaluation at this time? \_\_\_\_\_

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**Please Circle all terms that describe your child.**

- |                      |                      |                    |                           |                    |
|----------------------|----------------------|--------------------|---------------------------|--------------------|
| Hyperactive, fidgety | Short attention span | Poor concentration | Academic difficulties     | Delayed milestones |
| Hearing problems     | Vision problems      | Sleep problems     | Delays in speech/language | Loss of skills     |
| Eating problems      | Temper tantrums      | Conduct problems   | Loner, few friends        | Poor self esteem   |
| Bedwetting           |                      |                    |                           |                    |

Is this child: Biological / Adopted / In Foster Care / \_\_\_\_\_.

Check all those involved in raising this child: Mother / father / Grandparent / Housekeeper/Babysitter / Daycare worker / other (specify) \_\_\_\_\_

List all languages spoken by the child \_\_\_\_\_ List all languages spoken at home \_\_\_\_\_

School: \_\_\_\_\_ Address: \_\_\_\_\_ Tel: \_\_\_\_\_

Current Grade: \_\_\_\_\_ No. of years in this school \_\_\_\_\_ Has this child repeated a grade ? Y / N Grade: \_\_\_\_\_

List all schools previously attended if applicable:

<u>School</u>	<u>City/state</u>	<u>Grade</u>	<u>Years</u>
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List all members living in the same home as the child.

Name	Sex	Age	Occupation/Grade	Relationship

List all immediate family members not living in the same home as the child

Name	Sex	Age	Occupation/Grade	Relationship

List all previous evaluations done

<u>Type of evaluation</u>	<u>Date</u>	<u>Evaluation Site /Person/ address</u>
Psychological	_____	_____
Educational	_____	_____
Speech/Language	_____	_____
Hearing	_____	_____
Vision	_____	_____
Neurology	_____	_____
Psychiatry	_____	_____
Other	_____	_____

Please list all previous diagnosis or educational classifications made: \_\_\_\_\_

Please list all services received or currently receiving:

<u>Services</u>	<u>Dates</u>	<u>Times per week</u>	<u>Provider/Therapist</u>
Counseling/Psychotherapy	_____	_____	_____
Resource Room	_____	_____	_____
Self-contained class	_____	_____	_____
Tutoring	_____	_____	_____
Physical therapy	_____	_____	_____
Occupational Therapy	_____	_____	_____
Speech/Language Therapy	_____	_____	_____
Medication (stimulants)	_____	_____	_____
Other _____	_____	_____	_____

Please fill this if different from the registration sheet.

**Legal guardian** / Parent information: Single Married Divorced Separated Widowed Partnered with **( Please circle )**

Father/Parent/ Guardian's name: _____ (First) (Last)	Mother/Parent/Guardian's name: _____ (First) (Last)
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
SocSec#: _____ Birthdate: _____	SocSec#: _____ Birthdate: _____
Phone: Cell: _____ Work: _____	Phone: Cell: _____ Work: _____
Home: _____ Fax: _____	Home: _____ Fax: _____
Email address: _____	Email address: _____
Profession/Employer: _____	Profession/Employer: _____

**DEVELOPMENTAL BEHAVIORAL EVALUATIONS:** All evaluations to be scheduled in one or two sessions. Please bring all contributory records such as school reports or previous evaluations.

**Please take this informational sheet to review.**



Pediatric Associates of Farmington, LLC. 200 Mountain Road, Farmington, CT 06032. Tel. (860) 676-9000. Fax: (860) 676-1541

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9. **ELECTRONIC DEVICES:** Please do not use any electronic devices while in the office. Our patients and providers need your full attention and we request all to respect that.

**This is the only location of our office. Office Hours:** Mon/Tue/ Fri – 8.30 to 12 & 12.30-4.00 pm.  
Wed/Thu - 8.30 to 12 & 12.30- 5.00 pm

**Calls during office hours:**

Every call is answered as fast as possible. If the call is deemed urgent, the staff will get the provider out of the room. If it is a routine call, you can expect an answer either at lunch time or before the end of the day.

**After hours care**

**On call service** after hours at all times. Please call the office number 860-676-9000 to reach the on call provider. Dr. Limaye prefers to take calls for all her patients. When not available via phone, she has arranged for another colleague of hers to take the calls.