

**Thank you for scheduling an appointment with
Pediatric Psychological Associates!**

Please take time review www.pediatricpsych-alaska.com for important information about your child's assessment, fees, what to expect etc.

- Please complete your registration at www.therapyappointment.com if you have not done so.
- **Office Days: Monday/Wednesday = Anchorage office.
Friday = Wasilla office.**
Be sure your appt is scheduled for the office you expect 😊.

Payments: Due at time of appointment. We will bill your insurance company for your reimbursement.

For Triwest Patients ONLY:

Dr Norton will contact you to schedule a 1-hour intake appointment at least 2 weeks prior to your testing appointment, to complete a Triwest preauthorization request for your appt with you. (See our website for more information if desired.)

For Denali Kid Care Patients ONLY:

Be sure to bring your DKC card with current monthly sticker, or a clear copy of the front and back for our file.

Other insured Patients:

The office will bill your insurance company as a courtesy. Our website www.pediatricpsych-alaska.com has helpful insurance information. If your insurance requires prior authorization for psychological or neuropsychological testing, contact Dr. Norton (directly) for a 1 hour intake/prior authorization appt. Ask your insurance company to fax required forms if needed to: 907 334 9842. Prior to calling your insurance provider, we suggest a review of the info on our website.

Pediatric Psychological Associates Child and Adolescent Evaluation Intake

You may complete this packet on your computer and email to Dr Norton, or print out and complete by hand

Child's Name	Age	DOB	Grade
Mother's name	Age	DOB	
Mother's Occupation/Job	Employer		
Father's Name	Age	DOB	
Father's Occupation/Job	Employer		

Referral Source: Phone book ___ medical provider ___ friend ___ Internet ___ (which site?) _____

Please read the following information carefully and Initial each section

Your Rights

- You have the right and responsibility to participate in your treatment plan, and to communicate your needs and desires for treatment with me.
- You have the right to confidentiality. I may discuss treatment issues in case consultations with another therapist. In any event, I will not disclose client name or specific identifying information.
- I will not release any information without your written permission, with the following exceptions, in which I am legally required to:
 1. A Report known and suspected abuse or neglect or minors and/or vulnerable adults
 2. B Notify others if there is intent to harm yourself or another
 3. C Comply with court subpoena for records

Appointments initial _____

Testing sessions take a significant part of a day, so please arrive on time, with child fed, rested and with prepared with necessary paperwork.

Attendance and Cancellation Policy initial _____

Cancellations must be made at a minimum of 24 hours in advance **or a cancellation / no show fee of \$500.00 will incur** without extreme circumstances. The online appt schedule program can be set to remind you by phone, text or email of your appointment. Insurance companies do not reimburse no-shows, or late cancellations.

Crisis initial _____

If you feel you are in danger of hurting yourself or another, call the Mental Health Crisis hotline at 907 563 3200, Or go to your local Emergency Room.

Fees and Billing Policies initial _____

You may pay with your credit card, or directly with check or cash. Fees are due at end of each testing session. We will bill your insurance for your reimbursement.

Intake appointment: \$300. Average Psychological testing fees: \$800-1600 Average Neuropsychological Testing: \$2900

I give permission for my child to receive a psychological assessment with Dr Norton. I also understand the above information, and have reviewed the attached HIPAA notice and disclosure form.

Mother
Father

Date
Date

Pediatric Psychological Associates Child and Adolescent Evaluation Intake

Greetings,

Please complete this information as completely as possible. You may type your responses directly; use as much room as you want. Please return via email at drlnorton@mac.com or fax to 1- 877- 907 -7792 (psyc).

Please request your child's school to fax the following documents (or bring these to your appointment if possible):

- Past psychological evaluations
- Current IEP (Individual Education Plan for students receiving special ed)
- School 'ESER' report (results of school testing and eligibility report)
- School work samples
- Teacher comments if available

Directions to the office, information on insurance, fees, what to expect for testing etc are all listed on my website at: www.pediatricpsych-alaska.com I look forward to meeting you and working with your child.

CHILD AND ADOLESCENT INTAKE ASSESSMENT INFORMATION

Name of doctor/provider/school staff who referred you:

Describe below the specific difficulties or reasons for which your child is being evaluated. Please include a brief history.

How long have these problems occurred?

Do you perceive these problems to be: Crisis level serious becoming serious?

What specific information/answers/ changes do you and/ or your provider hope to obtain through this evaluation?

Family Information

Primary language spoken in the home:

Other languages spoken in the home:

Marriage status of caregiver/parents: ___married___living together
_____divorced___separated

Please list other children in the family/biological children from either parent

Names	Ages	Genders	In Home?	School/Behavior/Health Problems
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Pediatric Psychological Associates Child and Adolescent Evaluation Intake

Who lives in the home with child? (Include other relatives, friends etc) (Can circle the names above)

If you are married or living with a partner rate the quality/happiness of your relationship using a 1-10 scale. (one is very poor, 10 is excellent)

- Do you have supports/friends/ family in Alaska? 1-10
- Do you/your family enjoy living in Alaska? 1-10
- Rate your discipline/parenting effectiveness 1-10:
- Rate your spouse's effectiveness 1-10:
- Rate your pleasure with the parenting role: 1-10
- Rate your spouse's pleasure 1-10:
- What rating represents your family's happiness overall? 1-10

Do any extended family members play a significant role in the child's life?
If yes, who?

Any deaths in the immediate family during the past 12 months? Yes No

Indicate any stressful or traumatic events experienced by your child during his/her life such as:

- Family member deaths parents divorce separation family member illness
- witnessing domestic violence or excessive arguing sibling experiencing troubles
- witnessing alcohol use or substance use/abuse
- legal problems sexual abuse

Other:

Child's Medical History

Current health: Great Average Fair Poor

Please list any and all diagnoses your child has been given :
e.g., AD/HD, Learning Disabled, PDD, Tourette's, Bipolar, Depression, Anxiety, Asperger's, Autism, etc.):

Has your child ever had psychological counseling or therapy Yes No

If yes, counselor's name

For what issues?

When

Did you find it helpful?

Yes No

Has your child had a psychological or psychiatric evaluation?

Yes No

If yes, doctor's name

Date of Eval

Reason for exam

please bring a copy of report

Has your child been hospitalized in a psychiatric facility?

Yes No

If yes, When?

Where?

Reason?

Pediatric Psychological Associates Child and Adolescent Evaluation Intake

Please list your child history of serious illnesses, medical procedures, and surgeries, illnesses:

Medical Procedures/issues:

Surgeries:

Has your child had any head injuries or concussions? Yes No
If yes, please describe the incident whether your child lost consciousness and for how long.

Has your child ever had any hearing or vision problems? Yes No
Describe:

Has your child been diagnosed as ADHD Yes No
Is your child currently taking any medications? Yes No

Does your child have any history of alcohol or drug use? Yes No
If yes, please describe:

Has your child ever displayed any of the following: persistent headaches, dizziness, seizures, insomnia, significant changes in weight, or altered states of consciousness (ex. auditory or visual hallucinations)? Yes No

If yes, please explain:

Family Medical History

Place a check next to any illness or condition that any member of the extended family has had.

When you check an item, please specify family member's relationship to your son or daughter (please include "M" if the relative is from the mother's side or "P" if the relative is from the father's side)

<input type="checkbox"/> Alcoholism	Depression _____
<input type="checkbox"/> Cancer	Suicide attempt _____
<input type="checkbox"/> Diabetes	Heart trouble _____
<input type="checkbox"/> Migraine headaches	Hospitalized for mental illness? _____
<input type="checkbox"/> Tourette's syndrome	Birth defect _____
<input type="checkbox"/> Emotional disturbance	Mental illness _____
<input type="checkbox"/> Mental retardation	Nervousness/Anxiety _____
<input type="checkbox"/> Seizures or epilepsy	Reading problem _____
<input type="checkbox"/> Other learning disability	Severe head injury _____
<input type="checkbox"/> Substance abuse	Substance addiction _____
<input type="checkbox"/> Thought problems	Schizophrenia _____
<input type="checkbox"/> Other: i.e. mental illness diagnosis not listed:	

Please check all health problems the child has had.

<input type="checkbox"/> High fevers	<input type="checkbox"/> dental problems	<input type="checkbox"/> pneumonia
<input type="checkbox"/> Flu age:	<input type="checkbox"/> weight problems	<input type="checkbox"/> allergies
<input type="checkbox"/> Encephalitis	<input type="checkbox"/> skin problems	<input type="checkbox"/> convulsions
<input type="checkbox"/> Headaches	<input type="checkbox"/> high fevers	<input type="checkbox"/> unconsciousness
<input type="checkbox"/> Head injury	<input type="checkbox"/> stomach problems	<input type="checkbox"/> accident-prone
<input type="checkbox"/> Fainting	<input type="checkbox"/> anemia	<input type="checkbox"/> dizziness
<input type="checkbox"/> Tonsils out	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> low blood pressure
<input type="checkbox"/> Sinus problem	<input type="checkbox"/> vision problems	<input type="checkbox"/> heart problems
<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> hearing problems	<input type="checkbox"/> earaches

Pediatric Psychological Associates Child and Adolescent Evaluation Intake

Pregnancy, Birth, and Developmental Information:

Pregnancy

Did the mother have any accidents, infections, and problems during pregnancy? If yes, please explain:

Were any medications taken during pregnancy? If yes, please list and explain:

Did the mother smoke during pregnancy? If yes, how many cigarettes per day
How much alcohol did the mother consume during pregnancy (ex. 1 drink per day, Week, month)?

Birth & Postnatal

Indicate if any of the following conditions affect your child during delivery

Injured during delivery? If yes, please describe Yes No

Cardiopulmonary distress during delivery?

- Yes No cord around neck
- Yes No Had trouble breathing
- Yes No Needed oxygen
- Yes No Turned blue
- Yes No Was jaundiced
- Yes No Had seizures
- Yes No Was given medication –
- Yes No Born with problems?
- Yes No Was in hospital more than 7 days

Has anyone suggested your child may have developmental problems? Yes No

Was the infant full term? Yes No

If no, how many weeks premature or postmature (overdue)

Type of delivery: Caesarean (planned) Caesarean (unplanned) Normal

Any unusual characteristics of delivery? (ex. breech, induced) ? If yes, please explain:

What was his/her birth weight?

Was there any evidence of injury to him/her before or during birth? If yes, please

Explain:

Please list any birth defect

CHILD AND ADOLESCENT HISTORY FORM

If you are coming in due to behavioral issues, it is very helpful to keep track of this behavior for a week or two prior to your appointment. A simple daily note recording the # of times the behavior occurs, how long the behavior occurs, what started the behavior... or, bring in a video recording of the behavior.

Child's Strengths:

- | | | |
|--|---|--|
| <input type="checkbox"/> Enjoys sports | <input type="checkbox"/> Does well in school | <input type="checkbox"/> Enjoys music |
| <input type="checkbox"/> Enjoys arts/crafts | <input type="checkbox"/> Communicates well | <input type="checkbox"/> Energetic |
| <input type="checkbox"/> Leadership skills | <input type="checkbox"/> Coordinated/graceful | <input type="checkbox"/> Organized |
| <input type="checkbox"/> Cooperative/helpful | <input type="checkbox"/> Polite | <input type="checkbox"/> Affectionate |
| <input type="checkbox"/> Good social skills | <input type="checkbox"/> Responsible | <input type="checkbox"/> Independent |
| <input type="checkbox"/> Likes to read | <input type="checkbox"/> Good sense of humor | <input type="checkbox"/> Creative |
| <input type="checkbox"/> Honest | <input type="checkbox"/> Follows directions | <input type="checkbox"/> Good with animals |
| <input type="checkbox"/> Able to concentrate | <input type="checkbox"/> Participates in activities | <input type="checkbox"/> Respectful |

What is the best thing about your child?

What is a special interest, or skill, your child has?

Anything else you would like me to know so that I may best help you and your child?

*Thank you! You are done ☺
I look forward to meeting with you soon.
Email or fax this to:
DrLNorton@mac.com fax 1-877 907 7792 or 907 334 9843*

Please request your child's school to fax following information prior to your appt if possible:

- Recent 3 Year Evaluation results (if your child receives special education)
- Teacher comments on behaviors of concern (informal notes, emails etc are fine)

If you have testing information from other psychologists, pls bring a copy of the report.

CHILD AND ADOLESCENT HISTORY FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Lawrence Norton has been and will always be totally committed to maintaining clients confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes my policies related to the use and disclosure of your healthcare information. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. **State and federal law allows me to use and disclose your health information for these purposes.**

TREATMENT:

I may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources. I will send a copy of your child's testing results to your referring provider. (Unless you specifically ask me not to).

PAYMENT:

Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS:

I may need to use information about you to review my treatment procedures and business activity. Information may be used for certification, compliance and licensing activities. There are some instances where I may be required to use and disclose information without your consent as is indicated on page 1 of this packet, as well as information shared with law enforcement if a crime is committed on these premises or as required by law such as a subpoena or court order.

Client Rights

Right to request how we contact you. You will indicate online how you want to be contacted.

Your right to release your medical records. You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I acted in reliance on such authorization

Your right to inspect and copy your medical and billing records. You have the right to inspect and obtain a copy of your information contained in my medical records. To request access to your billing or health information, contact myself or Anne Norton. You will receive a copy of your testing results for your files.

Your right to add information or amend your medical records. If you feel that information contained in your medical record is incorrect or incomplete, you may ask to add information to amend the record. I will then require you to submit your request in writing and to provide an explanation concerning the reason for your request within 48 hours. I will then make a decision on your request with 60 calendar days, or some cases within 90 calendar days. Under certain circumstance, I may deny your request to add or amend information. If I deny your request, you have a right to file a statement that you disagree. Your statement and my response will be added to your record.

Your right to an accounting of disclosures. You may request an accounting of any disclosures, if any, that I have made related to your medical information, except for information that I used for treatment, payment, or health care operational purposes or that I shared with you or your family, or information that you gave me specific consent to release. It also excludes information that I was required to release.

Your right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to myself. However, I am not required to agree to such a request.

Your right to complain.

If you believe your privacy rights have been violated, please contact myself personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint. But of course, please talk with me about any concerns you may have. I value my patients' privacy greatly.