Child's Name: _____

Grade: _____

Birthdate: _____

Referred By: _____

Is Child Adopted? _____

Mother's Information

Name _____

Home Phone # _____

Work Phone _____

May I leave messages? _____

Occupation _____

Home Address _____

_____

_____

Mother's Age _____

Father's Information

Name _____

Home Phone # _____

Work Phone # _____

May I leave messages? _____

Occupation _____

Home Address _____

_____

Father's Age _____

People in household:

(names and ages) _____

_____

_____

_____

_____

_____

Circle items that pertain to your child:

- Diagnosed ADD
- Diagnosed ADHD
- Fidgety
- Extremely active
- Lack of self-control
- Doesn't remember rules
- Easily distracted
- Class clown
- Dreamy
- Isolative
- Sad or sullen
- Cries easily/often
- Excessive fears
- Destructive
- Lying
- Stealing
- Tantrums
- Bullies other kids
- Repeated grade
- Reading problems
- Learning problems
- In Special Ed classes

What changes would you like to see?

_____

_____

_____

_____

_____

_____

_____

_____

I authorize the ADD Diagnosis and Treatement Center to provide psychological service, including testing, for the child named above.

X_____Date_____

(Parent or guardian's signature)

Developmental History

Length of pregnancy: _____

Was delivery normal, breeched, or Cesarean section? _____

Duration of labor: _____

Were there any pregnancy complications? _____

_____

Medications used during pregnancy: _____

_____

Did mother smoke cigarettes during pregnancy? _____

Do parents currently smoke cigarettes? _____

Did mother drink alcohol prior to pregnancy? If yes, what type and how often: _____

_____

Do parents currently drink alcohol? If yes, how much and what type? _____

_____

Did mother use any type of drugs during pregnancy? _____

_____

Do parents currently use any type of drugs? _____

Baby's weight at birth: _____

Baby's length at birth: _____

Infancy and Early Childhood

Please circle all that apply:

Colicky	Did not enjoy cuddling
Feeding problems	Headbanging
Sleeping problems	Accident prone
Restlessness	Active

Child's approximate age when began:

Crawling: _____

Walking: _____

Talking (single words): _____

Speaking short sentences: _____

Toilet training: Daytime _____ Nighttime _____

Childhood

Was there any childhood surgery? _____

_____

Any other hospitalization? _____

_____

Please circle which of the following diseases your child had:

asthma	anemia
lead poisioning	meningitis
encephalitis	seizures
epilepsy	cerebral palsy
recurring ear infections	Other: _____

Medication currently taken:	For:
_____	_____
_____	_____
_____	_____

Name and speciality of doctor who prescribes the medication:

_____

_____

Please list any known learning disabilities or school problems:_____

_____

_____

_____

Does anyone else in the family have similar problems? _____

_____

_____

_____

Please list any unusual or traumatic events in this child's life, and the age at which they occurred:

_____

_____

_____

_____

_____

_____

_____

_____

Please use this space to tell us about anything else that you think is important to know about your child:

_____

_____

_____

_____

_____

_____

SOI *The Structure of Intellect*
COUNSELING AND TESTING CENTER

MANHATTAN BEACH, CA 90266 • (310) 546-6500 • FAX (310) 546-9068

CONSENT FOR RELEASE OF INFORMATION OR RECORDS

I hereby authorize _____ to mutually disclose records and/or information to _____, regarding _____, date of birth _____/_____/_____, obtained in the course of his/her diagnosis and treatment. This release will remain in effect for one year from the date below unless revoked.

These records are protected by the California Welfare and Institution Code Section 5328. Disclosure shall be limited to the information specified below (please circle):

Clinical Evaluation
Diagnosis
Discharge Summary
Diagnostic Exam
Results of Psychological/Vocational Tests
Educational Assessment & Behavioral Reports

_____ _____
Signature of client/parent/guardian/conservator Date

Date consent revoked _____

_____
Signature of client/parent/guardian/conservator

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION IF I SO REQUEST

Scott Wilson, MFCC
Counseling & Helliwork

Valerie Maxwell, Ph.D.
Director, Counseling & Testing
Psychologist Psy 9844

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

MDWizards.com

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

71b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

SOI Counseling and Psychological Testing Center
Dr. Valerie Maxwell, Director

Phone 310-546-8583
Fax 310-546-9068

Insurance Questionnaire / Payment Agreement

In order to determine what insurance benefits, you have available, we ***require*** you to contact your insurance company at the phone number listed on your insurance card and ask the following information. **Failure to fill this form out *COMPLETELY* will disable us from billing your insurance provider for services rendered. It is your responsibility to pay for any outstanding balance.** Psychological Services and Therapy are *confidential* processes to which we are legally and ethically bound. However, if you file for insurance benefits or reimbursement, please be aware that your confidentiality may be compromised.

Our office must receive this information BEFORE you will be scheduled for an assessment if you need authorization.

***Be sure you call or are transferred to the Mental Health department, *not* medical. When you reach a representative please state:**

"I AM CALLING TO CHECK MY OUTPATIENT MENTAL HEALTH BENEFITS."

1. **Is Dr. Valerie Maxwell a provider under my plan? Yes / No**
2. **Is my mental health insurance carved out to a different insurance provider? Yes / No**
   a. **(If #2 is Yes) What insurance covers mental health? _____**
3. **Is there a deductible for Psychological Testing or Counseling? (if none, enter "0"): $ _____**
   a. **(If #3 is *not* 0) Has the Deductible been met? Yes / No**
4. **What is my co-payment? _____**
5. **Do I need an authorization for mental health? Yes / No**
   a. **(If #5 is Yes) What is the authorization number? _____**
   b. **(If you have an authorization #) How many sessions are authorized to start? _____**
   c. **What is the start and end dates of the authorized sessions? Start_____ End_____**
6. **What is the MAXIMUM number of sessions I can use? _____**
7. **Do I need an authorization for Psychological Testing? Yes / No**
   Test Codes: 96130, 96131, 96136, 96137, 96138, 96139
8. **Address to send Mental Health Claims:**
   (Often times different than address on card, please ask)
   Insurance provider:_____
   Address:_____
   _____

11. **Ph# Called:_____**
    Date of Call:_____

I UNDERSTAND THAT ADDSOI CHARGES $1,000 FOR ADHD TESTING SERVICES. IT IS MY RESPONSIBILITY TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, WHETHER BECAUSE I FAILED TO OBTAIN AUTHORIZATION, DENIAL, OR LIMITATION OF BENEFITS, CO-PAY, ETC. I HEREBY UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE, I WILL MAKE ARRANGEMENTS TO PAY THE AMOUNT DUE.

_____ Signature

_____ Date

_____ Print Name

_____ Client Name (Print)

Our office reserves the right to charge an administrative fee of $25 if the answers on this form are incomplete or incorrect.