Pathways
Developmental Pediatrics
Personalized care for individual minds

Welcome to Pathways Developmental Pediatrics!

We are honored to be involved in the care of your child, and look forward to working with you to ensure your child reaches his/her full developmental potential.

We understand that having concerns about your child's development and behaviors can be scary and sometimes overwhelming. It's our goal to be a partner in care with you and provide support as you navigate this journey.

To prepare for your first visit, please use this checklist as a guide. We are looking forward to working with you!

New Patient Telemedicine Checklist

- Please *Upload* the following completed forms to your initial visit appointment. This will ensure a complete evaluation. Dr. Frazier will review them just prior to your telemedicine visit. ***For privacy, forms sent via email, and not the secure scheduling platform, are not reviewed, and are shredded.***

- Please refer to the FAQs on our website for additional information on how to prepare for your Telemedicine visit.

❏ Completed Registration Form
❏ Completed Parent Questionnaire
❏ Completed Teacher Questionnaire (if possible)
❏ Completed Strengths and Difficulties Questionnaire
❏ Signed Telemedicine Consent Form
❏ Signed Financial and Cancellation Policy Form
❏ Signed Credit Card Authorization Form
❏ Copies of prior evaluations including: IEPs, psychological testing, educational testing, speech, and occupational therapy assessments. (these can be uploaded separately)
❏ *Read* the Notice of Privacy Practices listed on our website.

232 Douglas Avenue, Suite A ○ Charlottesville, VA 22902 ○ P: 434-218-0862 ○ F: 434-473-6025
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Patient Registration

Contact Information

Today's Date: _____

Child's Full Name: _____

Nickname:_____ Gender:_____ Date of Birth_____

Parent 1: _____ ☐ Mother ☐ Father ☐ Guardian
Full Name

_____
Street Address City, State Zip Phone Number

Parent 2: _____ ☐ Mother ☐ Father ☐ Guardian
Full Name

_____
Street Address City, State Zip Phone Number

Best number where you can be reached?_____

Emergency Contact Information: _____
Name

_____
Relationship Phone

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

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Billing Information

Primary Insurance Co: _____ Member ID#_____

Policy Holder's Name: _____ DOB: ___/___/___

Secondary Insurance Co: _____ Member ID# _____

Policy Holder's Name: _____ DOB: ___/___/___

Consents

Consent to Treatment of a Minor Child:

I request and authorize Pathways Developmental Pediatrics PLC, physician(s) and staff to perform necessary services for my child which are deemed advisable by the physician(s), whether or not I am present at the appointment.

_____ **(INITIAL)** I hereby authorize the following individuals to bring my child, listed above, in for treatment. These named individuals may also receive test results, and information pertinent to the treatment and care of my child.

1. _____

   Name Relationship to Patient Phone

2. _____

   Name Relationship to Patient Phone

3. _____

   Name Relationship to Patient Phone

4. _____

   Name Relationship to Patient Phone

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Consent to Receive Emails and Text Messages about Appointment Reminders:

_____ (INITIAL) I consent to receive emails and text messages from Pathways Developmental Pediatrics, PLC at my cell phone number, and any number forwarded or transferred to/from that number to receive appointment reminders. I understand that this request to receive emails and text messages will apply to all future appointment reminders unless I request a change in writing.

The email that I authorize to receive messages for appointment reminders is:

_____

The cell phone number that I authorize to receive text messages for appointment reminders is:

_____

Note: Pathways Developmental Pediatrics, PLC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

_____ (INITIAL) I permit Pathways Developmental Pediatrics, PLC and the physician(s) or other health professionals involved in care to release healthcare information for purposes of treatment, payment or healthcare operations.

The above is in effect until revoked in writing by me, and receipt acknowledged by Pathways Developmental Pediatrics PLC.

_____

Parent/Guardian Signature **Name** **Date**

Acknowledgement of Notice of Privacy Practices

I was provided a copy of Pathways Developmental Pediatrics, PLC Notice of Privacy Practices which outlines how this practice may use and disclose my protected health information. I have been able to review and ask questions about the content in this notice.

I am aware that there is an additional copy of the Notice of Privacy Practices on the website of Pathways Developmental Pediatrics, PLC as well as posted in their clinic.

I acknowledge that I have received the Notice of Privacy Practices.

_____

Parent/Guardian Signature **Name** **Date**

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New Patient Parent Questionnaire

Date: _____

Child (Patient) Name: _____ Nickname: _____

Person(s) Completing This Form: _____

Relationship to Child: _____

PRESENTING CONCERNS

Who recommended this evaluation, and why?

What concerns do you have about your child? What are the goals you have for this evaluation?

How long have you had these concerns? Was there anything that brought these concerns to your attention? What have you tried that has worked, or that has not worked, to help?

Has your child ever been diagnosed with any of the following?

__ Developmental Delay __ ADHD __ Sensory Processing Disorder

__ Autism Spectrum Disorder __ Learning Disability __ Mood Disorder(s)

What are your child's special qualities or strengths?

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MEDICAL HISTORY

Pregnancy, Labor, and Delivery

What number pregnancy was this for the birth mother? _____

Was your child conceived through any forms of assisted reproduction or egg/sperm donation?

_____

How many weeks gestation was your child when he/she was born? _____

Were there any fertility difficulties with this pregnancy? Circle: YES NO

If yes, please describe: _____

_____

Birth Weight: _____Delivery Method? Circle: VAGINAL CESAREAN SECTION

Please circle any complications which occurred during the pregnancy:

High blood pressure	Maternal stress/trauma	Non-Prescribed drug use
Alcohol use	Fetal Distress	Preterm Labor
Tobacco use	Infections	Bleeding

Please describe: _____

_____

Please circle any issues your child experienced as a newborn:

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Jaundice	Irritability	Poor weight gain
Low glucose	Arousal difficulties	Oxygen requirement

Please describe: _____

_____

Past Medical History

Please list all prior diagnoses your child has been given:

_____ _____

_____ _____

_____ _____

_____ _____

Please list any medications your child is ***currently*** taking:

_____ _____

_____ _____

_____ _____

Please list any medications your child has taken in the ***past***, and why they were discontinued:

_____ _____

_____ _____

Allergies and Drug Reactions: _____

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DEVELOPMENTAL HISTORY

Were there ever any delays noted in your child's development? If so, please describe.

Was your child involved in Early Intervention? If so, please describe the services he/she received and attach a summary from the Early Intervention evaluation.

HOME LIFE

Who lives at home with your child? (parents, siblings, grandparents, etc.)

If in foster care, please explain the circumstances leading to foster care.

If parents are not together, please describe custody arrangements and visitation frequency.

Is there anything which you feel is important for this evaluation which you do not wish to discuss in front of your child?

What, if anything, does your child know about his/her prior medical or developmental diagnoses? You may find the "Dialogue to Child" listed on our website helpful to read prior to your appointment.

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Has your child been exposed to any particularly stressful experiences such as bullying, inappropriate touch or abuse, violence, parental marital problems, or death of a loved one? If yes, please describe.

FAMILY HISTORY

For the purposes of understanding possible genetic risk factors, this section refers to what is known about any biologically related relatives of your child.

Age of mother at child's birth: _____Occupation: _____

Age of father at child's birth: _____Occupation: _____

Please describe any medical or developmental concerns which occur in your child's (genetically related) family members. Consider immediate family in addition to more distant relatives such as grandparents, cousins, aunts.

Diagnosis/Condition	Check if Applicable	Family Member (relationship to child)
Autism		
ADHD		
Learning Difficulties		
Intellectual Disability		
Speech Delay		
Bipolar Disorder		
Depression		

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Anxiety		
Schizophrenia		
Alzheimer's Disease		
Cancer		
Cardiac/Heart Disease		
Early Death		

SCHOOL INFORMATION

Name of school or daycare where your child attends: _____

Grade Level: _____

Does your child receive any specialized support(s) in school? circle

IEP Occupational Therapy504 Plan Speech Therapy Accommodations

We do not communicate with your child's school without your written permission. **Please be sure to bring a copy of your child's IEP, testing results, therapy reports, or 504 Plan.**

ADDITIONAL INFORMATION

Is there anything else that you would like us to know? Please share any additional comments or concerns.

Please complete if your child is 2-4 years old

Strengths and Difficulties Questionnaire

P or T 2-4

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Can stop and think things out before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

Please complete if your child is 5 years old or older

Strengths and Difficulties Questionnaire

P or T 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

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Teacher Questionnaire
****Please only complete if feasible, this is no longer required!****

Parent to complete top box:

Child's Name:_____Date: _____

Teacher's Name completing this form: _____

School: _____Grade: _____

Class(es) taught: _____

Dear Teacher,

We would like to better understand the child listed above. Please complete this form in as much detail as possible, adding additional information if needed. We value your input, and greatly appreciate your time.

1. Does this child receive any specialized supports? This includes supports through a formalized IEP/504 Plan, as well as any informal supports which you may provide.

2. Please describe any concerns you have about this child's learning.

3. Does this child exhibit any unusual behaviors? Does he/she have behavioral challenges which interfere with learning or social interactions?

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4. How does this child interact with peers?

5. What are this child's strengths in school?

6. How have you found that this child learns best?

7. Is there anything additional that you feel is important to share about this child?

Teacher's Signature **Written Name** **Date**

Thank you for completing this form!

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Telemedicine Consent Form

Today's Date:_____

Child's Name:_____ _____ Child's Date of Birth: _____
First Last

1. I understand that my health care provider, Dr. Evelyn Frazier at Pathways Developmental Pediatrics wishes me/my child to engage in a Telemedicine visit.
2. I hereby authorize and voluntarily consent to Pathways Developmental Pediatrics and Dr. Evelyn Frazier to provide me/my child with basic treatments and medical and diagnostic procedures.
3. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction,and may receive copies of this information for a reasonable fee.
6. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at this time. My provider has explained the alternatives to my satisfaction.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care. But that no results can be guaranteed or assured.

By signing this consent, I authorize my health professional to release any and all relevant information to my insurance company or any other agent which may be responsible for paying my medical bills.

I have read this document carefully, and hereby consent to participate in the Telemedicine Consultation under the terms described above.

_____ _____ _____
Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**

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Financial and Cancellation Policy

Patient Name: _____
Last First Date of Birth

Pathways Developmental Pediatrics is a private practice dedicated to providing personalized care for patients and families. Discussing and understanding financial and patient responsibilities is an important step in our partnership, and one that helps to ensure an aligned and sustainable medical relationship.

Please read this thoroughly and ask Dr. Frazier any questions that you may have

Patient Visits:

- I understand that Pathways Developmental Pediatrics participates in select insurance plans as listed on the website. Dr. Frazier is an out of network provider for all other insurance plans.
- I understand that I am responsible for determining if referrals are necessary for insurance reimbursement, and requesting these referrals.

For participating insurance plan holders:

- I understand that all services will be submitted to my insurance plan. Coinsurance and deductibles are my responsibility, and will be accepted at the time of service.
- I understand that some services may not be reimbursed by my insurance plan, and I agree to pay any balances not covered by my insurance plan as outlined in the Fee Schedule.
- I acknowledge that my insurance card must be available at the time of service, or I will be charged the fee-for-service rate.

For all other health insurance policy holders:

- I agree to pay for each visit at the time of service in accordance with the published fee schedule.
- I understand that payment is due at the time of service.

Parent's Initials: _____.

Payment Policy:

- Pathways Developmental Pediatrics uses a secure, third party appointment booking program. This company stores your credit card payment information, and only the last four digits of your credit card number can be seen.

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- I understand that co-pays and other out of pocket expenses will be charged at the completion of my appointment to the credit card I have put on file.
- I understand that out of pocket expenses incurred between visits will be charged to this credit card on file immediately. These expenses include, but are not limited to, no-show/late cancellation fee, telephone encounters, refills, and forms fees.
- If my participating insurance policy is subject to deductibles and/or co-insurances that cannot be collected at the time of service, I understand that Pathways Developmental Pediatrics will charge my credit card on file any outstanding balances as outlined on my Explanation of Benefits (EOB).
- It is my responsibility to understand my insurance policy and if referrals or prior authorizations are required.
- I agree to update my credit card on file when needed. I will receive a paper statement, which must be paid within 30 days, in the event my credit card on file cannot be charged.
- Payment of all statements is due upon receipt in order to remain in good standing with the practice. If charges remain unpaid, despite reasonable efforts on the part of Pathways Developmental Pediatrics to secure and notify me of necessary payments, I understand that my statements will be sent to a collection agency, and that treatment at Pathways Developmental Pediatrics cannot ethically be continued.

Parent's Initials: _____.

Cancellation Policy:

- I understand that I will be charged 50% of the visit fee if I cancel less than 48 hours prior to my appointment time, or after 11am on Fridays for Monday appointments.
- I understand that I will be charged the full visit fee if I cancel 24 hours prior to my appointment time, or no-show for my appointment without cancellation.

Parent's Initials: _____.

Late Arrival Policy:

- Dr. Frazier wants all patients to have the opportunity to be seen for his/her entire scheduled visit time. Thus, she operates under a "therapist" model; meaning, each appointment has a dedicated length of time.
- I understand that arriving late for my appointment may result in my visit being truncated to allow for others to be seen on time.
- I also understand that a shortened visit may result in an incomplete assessment, and I may need to return for further assessment.
- I also understand that if I arrive late for the visit, I may not be seen, and will still be required to pay for the appointment.

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Parent's Initials: _____.

Telephone Policy:

- I understand that often, I will be asked to schedule an appointment if issues or questions arise between scheduled appointment times.
- I understand that the best way to discuss my child's care is in a scheduled office visit. I agree to pay an out of pocket encounter fee if I require non-emergent telephone communication between office visits regarding my child's care.

Parent's Initials: _____.

Refill Policy:

- I agree to request all refills at the time of my visit.
- I understand that if I cancel or reschedule an appointment, I may run out of my child's required medication.
- I agree to pay $50 for any refill required between appointment times.

Parent's Initials: _____.

Forms/Paperwork Policy:

- I understand that requesting paperwork and form completion is best done during my child's appointment.
- I agree to pay the out of pocket fee of $50 for any letters, forms, or other paperwork that require completion by Dr. Frazier, outside of scheduled appointment times. I understand that I can avoid this charge by scheduling an appointment, and bringing these forms with me to this office visit.
- Records are provided at appointment times upon request. There is a $35 fee for records requested outside of appointment times.

Parent's Initials: _____.

Attorneys and Courts:

- In the event Dr. Frazier is required to work with your attorney, or is required to appear in court, the current hourly rate, billed by the quarter hour, will be charged, based on the most recent Attorney Fee Schedule.
- Additionally, you are responsible for fees issued from the Practice Attorney of Pathways Developmental Pediatrics.

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Parent's Initials: _____.

Financial and Cancellation Policy Agreement

I have read and agree to the above financial and billing policies.

_____

Parent Signature **Written Name** **Date**

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CREDIT CARD ON FILE AUTHORIZATION FORM

Today's Date: _____

Patient Name: _____Date of Birth: _____

At Pathways Developmental Pediatrics, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. This includes, but is not limited to, co-payments, and payments toward your deductible.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize and request Pathways Developmental Pediatrics to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.This authorization relates to all payments not covered by my insurance company for services provided to me by Pathways Developmental Pediatrics.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Pathways Developmental Pediatrics in writing and the account must be in good standing.

Guardian's Name (Print): _____

Signature: _____ Date: _____ / _____ / _____