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CONTRACT FOR THE EVALUATION FOR CHILDREN WITH PROBLEMS WITH BEHAVIOR AND/OR LEARNING

CHILD'S NAME: _____ DOB: _____

Our office has specific guidelines for the initial evaluation and ongoing management of our patients that have problems with behavior and/or learning. If you would like our office to evaluate your child/adolescent, it is important that these guidelines be followed.

INITIAL EVALUATION (CHILD, < 12 years old): This evaluation is divided into two (2) separate days:

Part 1: The first session will be scheduled for 1 hour and is typically for the parent(s) only.
Part 2: The second visit will be scheduled for 1 hour within 1-4 weeks of the initial visit and includes parent and child.

INITIAL EVALUATION (ADOLESCENT, >12 years old): This evaluation is usually scheduled as one visit divided into two parts: a session with the parent(s) and a session with the adolescent and lasts approximately 1 hour.

MEDICATION CHECK-UPS: If your child/adolescent is prescribed medication, we will see him/her one month after beginning med and then every 3-4 months for follow-up visits. These visits are not only extremely important for the management of your child/adolescent, but they are a requirement per the National Committee for Quality Assurance (NCQA). Prescriptions cannot be continued without these visits!!!

MEDICATION REFILLS: There is a $10/$15 charge to fill medication between visits. $10 if there is a card on file & $15 if there is NO card on file. Medications will not be filled if Med Checks are not up to date. Med Checks must be scheduled 3 months after last med check before we can send medication out.

**CANCELLATION OF EVALUATION APPOINTMENTS: If you need to cancel your evaluation appointment, you must cancel at least 72 hours (business day hours) before the appointment. Due to the appointment length and the high demand for these appointments, at least 72 hours are needed to refill the open appointment slots. If the evaluation appointment must be cancelled less than 72 hours before the appointment, a fee of $50.00 will be charged and you will be referred to a neurologist or psychologist/psychiatrist for the evaluation. Our office will continue to see your child for physical examinations and sick appointments.

PAYMENT: If your insurance does not cover the testing, you will be responsible for payment in full. If Medication refill is requested, I authorize the card on file to be charged. I understand I can call the office for a recipt of the transaction.

PARENT: By my signature, I acknowledge that I fully understand the terms listed above.

Parent/ Patient Signature _____ Date _____