Emerge
Professionals in Autism, Behavior & Personal Growth

400 South Colorado Blvd, Suite 860, Glendale, CO 80246
Phone: 303.322.9000 – Fax: 303.322.9001
info@emergeprofessionals.com

Client Registration Form – Child/Minor

Date Completed: _____

Client Legal Name (Last, First, MI):_____

Physical Street Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Mailing Address (if different): _____

Date of Birth: _____ **Age**: _____ **Sex**: _____

Social Security Number: _____ **School Grade**: _____

Diagnosis: _____

Other Conditions: _____

Ethnicity of Client (check all that apply):

African-American_____ Asian-Pacific_____ Caucasian_____ Hispanic_____ Other_____

Language(s) spoken at home: _____

Religious/Spiritual/Cultural Beliefs: _____

_____

_____

Mother/Legal Guardian Name: _____

Mother/Legal Guardian Date of Birth: _____

Relationship to client (*please check one*): Biological_____ Adoptive_____ Step_____ Foster_____

Address: _____

Phone: Home_____ Work_____ Cell_____

Email: _____

Occupation: _____

Highest Level of Education Attained (please circle):

High School: 9 10 11 12 College: 1 2 3 4 Graduate School

Employer Name: _____

Employer's Address: _____

Employer's Phone: _____

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Father/Legal Guardian Name: _____

Father/Legal Guardian Date of Birth: _____

Relationship to client (*please check one*): Biological_____ Adoptive_____ Step_____ Foster_____

Address: _____

Phone: Home_____ Work_____ Cell_____

Email: _____

Occupation: _____

Highest Level of Education Attained (please circle):

High School: 9 10 11 12 College: 1 2 3 4 Graduate School

Employer Name: _____

Employer's Address: _____

Employer's Phone: _____

Parent's Marital Status (check): Married_____ Separated_____ Divorced_____ Single_____ Widowed_____

Child Lives with (check all that apply): Father_____ Mother_____Other_____Specify_____

Client's Siblings:

Name_____ Age_____ Gender_____

Name_____ Age_____ Gender_____

Name_____ Age_____ Gender_____

Name_____ Age_____ Gender_____

Client's Primary Care Physician:

Name: _____

Clinic/Company Practice Name: _____

Address: _____

Phone: _____ **Fax**: _____

Email: _____

Would you like Emerge to exchange clinical information with your child's PCP or other mental health/behavioral/medical provider? (please check one) Yes_____ No _____ N/A _____

*****If yes, please complete the included Release of Information form for each provider*****

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Client Questionnaire

Client Name: _____ **Date**: _____

PART 1 - Concerns and Strengths

What specific concerns do you have about your child?

_____

_____

_____

_____

_____

_____

When did you first develop these concerns?

_____

_____

_____

_____

_____

_____

Whom have you seen previously about your concerns and what were you told about your child?

_____

_____

_____

_____

_____

_____

What are your child's interests and strengths? What does he/she like to do?

_____

_____

_____

_____

_____

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What questions would you like answered during the evaluation (if applicable**)**?

_____

_____

_____

_____

What agency or individual referred you to Emerge?

Name: _____

Address: _____

Phone: _____

PART 2 - Family History

Is there any history of the following on either side of the child's biologic parents' families? If yes, please indicate with and "X" on Father's or Mother's side or other blood relative (please indicate who).

Description	Father	Mother	Other Blood Relative: Specify
Psychological/Emotional Problems			
Mental Retardation			
Learning Disabilities			
Birth Defects			
Seizures/Convulsions			
Tuberculosis			
Neurological Disease			
Diabetes			
Cancer			
Allergies/Asthma			
Gland Disorder/Thyroid			
Hearing Impairments			
Vision Impairments			
Hyperactivity			
Miscarriages			
Slow Development			
Autism			
Fragile X			
Speech Problems			
Other:			
Other:			

Please explain any conditions present on either side of the family.

_____

_____

_____

_____

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PART 3 - Pregnancy and Birth History

Please list all pregnancies and miscarriages of child's biological mother (in chronological order**).**

Birth Date	Birth Weight	Health or Development Description

Please describe anything unusual or exceptional about the pregnancy and/or birth of the client.

_____

_____

_____

The baby was born: Early____ Late____ On Time____ Number of Weeks_____

The baby was born by: Normal Vertex (head down) ____ Breech____ C-section____

Baby's birth weight:_____lbs _____oz **Length**: _____inches **Apgar Score:**_____

Are biologic parents related to one another by blood: No_____ Yes_____: How: _____

Please check any of the following if present during pregnancy or birth.

☐ Excessive Bleeding	☐ Fever	☐ Rash
☐ Prescription Drugs	☐ Toxemia	☐ Poor Weight Gain
☐ Illicit/Street Drugs	☐ Cigarettes	☐ Narcotics
☐ Alcohol	☐ Supplemental Oxygen	☐ Illnesses

Please check any of the following if present during newborn period.

☐ Jaundice	☐ Feeding Difficulties	☐ Suspicion of Infection
☐ Poor Temperature Control	☐ Poor Activity	☐ Other

PART 4 - Nutritional History

Breast Fed: Yes____ No____ **For how long**? _____ months

Formula Fed: Yes____ No____ **Name of Formula**: _____

When were foods added: _____

When weaned to a cup: _____

Weight at one year: _____lbs _____oz

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Do you have concerns about your child's current eating habits/diet?

_____

_____

_____

_____

_____

PART 5 - Development History

Developmental Milestones: Write down the age when your child first did each of the following. Write "NA" if your child has not done it yet. Write "DK" if you don't know/remember.

Smiled		Held Head Erect		Separated Easily from Mother	
Imitated Sounds		Rolled Over		Ate Unaided with Spoon	
Said "Mama" or "Dada"		Sat Alone		Knew Colors	
Said other single words		Crawled		Started Counting	
Followed simple directions		Walked Alone		Recited Total Alphabet	
Said 2 to 3 word phrases		Rode Tricycle		Read Words	

In general, did you feel that your child developed: Quickly_____ Typically_____ Slowly_____

Temperament: Please comment on the following behaviors for your child as an <u>infant and as a toddler</u>.

- How active is your child? _____

  _____
- How well does your child deal with transition and change? _____

  _____

  _____
- How well does your child respond to new places, people and things? _____

  _____

  _____
- What is your child's basic mood? Happy____ Sad____ Angry____ Quiet____ Other_____
- Is your child predictable in patterns of sleep, appetite, etc? _____

  _____

  _____

  _____

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PART 6 - Medical History

Please indicate if the following are relevant to your child currently or in the past. Check "Yes" or "No". If yes, please explain. You may use the back of the form if you require additional writing space.

Description	Yes	No	Explanation/Specify/Treating Doctor's Name
Abdominal Pain/Bowel Issues			
Allergies			
Anemia			
Birth Defects			
Blood Disorders			
Concussion/Head Injury			
Dental Problems			
Drooling			
Ear Infections			
Eating Issues/Gags/Chokes			
Headaches			
Hearing Loss			
Heart Condition			
Hormone Problems			
Ingestion of Poisons			
Joint or Bone Problems			
Lung/Breathing Problems			
Seizures or Convulsions			
Significant Accidents			
Skin Disease			
Tics or Repetitive Behavior			
Urinary Problems/Infections			
Other Medical Concerns			

Child's Current Weight: _____lbs _____oz **Child's Current Height**: _____ft _____in

Are your child's immunizations up to date? Yes_____ No_____

List any hospitalizations and operations of the client. Please include approximate dates: _____

_____

_____

_____

_____

_____

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List all medications that your child is currently taking.

Medication Name	Dosage	Frequency	Prescribing Doctor Name

Please indicate if the following actions are relevant to your child currently or in the past. Please check "Yes" or "No" and if yes, please explain/specify. You may use the back of the form if you require additional writing space.

Description	Yes	No	Explanation/Specify
Aggression			
Bedwetting			
Breath Holding			
Cruelty of Animals			
Destructiveness			
Difficulty Toilet Training			
Disobedience			
Distractibility			
Eating Problems			
Hair Pulling			
Masturbation			
Mood Swings			
Nail Biting			
Poor Concentration			
Self-injurious Behavior (i.e.: head banging)			
Sleep Problems			
Temper Tantrums			
Thumb Sucking			
Unusual Fear			

Any other behavior issues that you would like to mention or explain?

_____

_____

_____

_____

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Does your child do any of the following? Please check "Yes" or "No" and explain if necessary.

Description	Yes	No	Explanation
Get along with other children			
Become easily upset or frustrated			
Become angry or destructive easily			
Become overactive			
Prefer to be alone			
Misbehave frequently			
Have difficulty sitting still			
Have any problem with awkwardness or clumsiness			
Listen well			
Follow spoken directions			

Please list all of your child's current and previous mental/behavioral health providers. Please also include any past developmental evaluations or testing your child has had.

Provider Name	Service Provided	Approximate Dates	Outcome and/or Diagnosis

How do you discipline your child? Please give an example.

_____

_____

_____

_____

_____

_____

_____

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PART 7 - Educational Profile

Please indicate the schools your child has attended in chronological order from current to oldest.

School Name	Grade/Level	Dates Attended

Has your child ever received special education services? **Please explain**.

_____

_____

_____

_____

_____

_____

Describe any current school programs.

_____

_____

_____

_____

_____

_____

Does your child or family utilize any other community resources (support groups, social services, etc)? Please list.

_____

_____

_____

_____

_____

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Please tell us what you consider to be important goals for your child in the following areas:

Communication:

_____

_____

_____

_____

_____

Social Skills and Relationship Development:

_____

_____

_____

_____

_____

Sensory Integration and Motor Skills Development:

_____

_____

_____

_____

_____

Structured Learning, Pre-Academics and Academic Skills:

_____

_____

_____

_____

_____

Is your child or family currently involved in any legal issues? If yes, please explain.

_____

_____

_____

_____

_____

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As a family, we'd like to be able to…

Places in the community that we enjoy are…

Emerge, P.C. can help our family by….

If you feel that there is additional information you would like to provide that would help us to know you or your child better, please include that information below.

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Client's Name (please print) _____ Client's DOB _____

Emerge Mandatory Disclosure Statement

As we begin our work together at Emerge we want to provide you with some important information about who we are, what to expect and what rights you have.

1. We believe that neuropsychological assessment and mental health treatment is a partnership; an agreement to work together to solve problems and help individuals grow. To this end, various assessment measures and treatment tools, including individual, group, play or family therapy and Applied Behavior Analysis (ABA) may be used. We are glad to talk with you in more detail about therapeutic orientations, tools and assessment procedures if you so desire. The clinicians involved in working with you will collaborate with you to decide what is most appropriate and helpful for you. Our goal is always to help patients learn ways to grow and thrive independently.

2. The fee for Initial Consultations is $150 per 50 minutes payable at the time of service. Psychological evaluations and other consultations may be charged at different rates, depending on individual cases and the individual clinician's rate. All services, including telephone consultations and after-hours services will be charged at the clinician's hourly rate. Phone consultations will be billed in 15 minute increments, rounded up to the nearest quarter hour. Emerge has a billing company who performs all commercial billing. It is your responsibility to contact Ponderosa Billing Services at 1-800-452-9284 and work with them to determine your insurance eligibility and your financial responsibility.

3. Full fees for such evaluations range from approximately $500 to $2,200. Academic testing is typically not covered by insurance companies. All copays, deductibles, and coinsurance will be collected in full before services are rendered. If you are ill or you have been ill in the 24 hours prior to the appointment, you must cancel the appointment as soon as possible. If you have a planned absence, you must notify your clinician no less than 2 weeks prior to the appointment. If you no show or cancel an appointment less than 24 hours in advance, Emerge reserves the right to charge clients 50% of the clinician's hourly fee. Emerge also reserves the right to charge 50% of the clinician's hourly fee for cancellations due to illness or planned absences in which the clinician is not notified by the timeline above. Charges will be assessed by the hour for the full time of the appointment.

4. Fee's for individual, couples or family treatment services depend upon the services desired and the clinician's expertise. Your treatment team will provide this information to you in a separate form. We have a large treatment team to meet the needs of your family and you may receive services from several clinicians if this is deemed to be the most appropriate treatment plan.

   Neuropsychological and psychological assessment services and psychological treatment services may be provided by:

   Helena Huckabee, Ph.D., BCBA-D
   Anna Kroncke, Ph.D., NCSP

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Leigh-Ellen Curl, Ed.S., NCSP
Jessica Reinhardt, Ph.D., Postdoctoral Fellow
Paul Grimsley, M.A., LAC
Alana Liskov, M.A., Doctoral Practicum Student
Chesleigh Keene, M.A., Doctoral Practicum Student
Jesse Wynn, M.S., Doctoral Practicum Student
Melissa Toppel, B.S., Psychology Practicum Student
Khalid Mohammad, B.S., Psychology Assistant

Applied Behavior Analysis Services may be provided by:

Helena Huckabee, Ph.D., BCBA-D
Tasha Jamroz, M.A., BCBA,
Suzanne Aurelio, M.S., BCBA
Meghan Weatherly, M.S., BCBA
Allison Clifford, M.S., BCBA
LisaMarie Callihan, M.A., BCBA
Bridget Cyr, B.A., BCaBA
Liz Cason, M.A.
Shaun D'Arcy, RBT
Jaclyn Hamlin, B.A.
Claire Findlay, B.A.

5. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Colorado Department of Regulatory Agencies can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a Bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical Masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

6. The Behavior Analyst Certification Board has the general responsibility of regulating the practice of certified behavior analysts. They provide and enforce guidelines of responsible

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conduct of behavior analysts. Behavior Analyst Certification Board, 1705 Metropolitan Blvd. Suite 102, Tallahassee, Florida 32308, (850) 765-0905

7. Client Rights and Important Information:

    a. You are entitled, to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure.
    b. You can seek a second opinion from another therapist or terminate therapy at any time.
    c. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
    d. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 and the Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child and elder abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

8. If you have any questions or would like additional information, please feel free to ask.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____ _____

Client's Printed Name **Client's DOB:**

_____ _____

Client's Signature (or Parent/Guardian) **Date**

_____

Parent/Guardian Printed Name

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_____ _____
Client's Name (please print) Client's DOB

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Financial Agreement

Because every insurance policy or funding agency is different, it is impossible for us to know all of the details of your specific plan or anticipate how the payer of benefits will construe or interpret the plan. All clients must work with our contracted billing company to determine eligibility and financial responsibility for services. It is the client's responsibility to ensure all preauthorization is in place prior to service and to comply with all requirements of any insurance plan the client may rely on for coverage of Emerge charges.

Please read over and sign your initials next to each policy.

_____ Your co-pay, deductible and/or co-insurance are due at the time of service.

_____ All balances not covered by your insurance company or health benefit plan become your responsibility. You will be sent a statement for any balance that you owe. This amount is due upon receipt and will be considered delinquent if not paid within 30 days after the statement has been issued. If an overpayment occurs on your account, we will send a refund within 30 days.

_____ In the event your account becomes delinquent, we will assess charges in the amount of 1.5% per month (18% per year) on all unpaid balances. If your account is still delinquent after 90 days, the account will be turned over to our contracted collection agency. Any and all fees associated with collecting balances, including but not limited to collection fees, legal costs, attorney fees, and interest are your responsibility.

_____You are responsible for notifying your clinician(s) of planned absences no less than 2 weeks prior to the absence in order to avoid a charge. If you no show or cancel a session for reasons other than illness less than 24 hours prior to the session, the clinician reserves the right to charge 50% of the clinician's hourly rate. This rate will be billed for the full amount of time scheduled for the (now) cancelled appointment. For example, if the session was scheduled for 1.5 hours, the client could be billed for 1.5 hours at 50% of the clinician's normal hourly rate.

_____ Excessive planned absences may result in your clinician(s) being re-assigned to other cases in order to maintain their caseload and corresponding compensation.

____ Your clinician(s) reserves the right to cancel sessions due to clinician illness or poor weather conditions at the clinician's home or your home. Sessions cancelled by the clinician will **not** incur a cancellation fee.

_____ If you or your child (the client) are ill and have experienced the symptoms below in the 24 hours prior to your session, we require that you cancel the session as soon as possible. If the clinician does report for a session and the symptoms listed below are present, that clinician reserves the right to leave and the session will be considered canceled. The clinician reserves the right to charge 50% of the clinician's full hourly rate for unexpected cancellations.

- **fever over 100 degrees, vomiting or diarrhea, or appear to be experiencing flu-like symptoms**

_____ If you need to cancel a regularly scheduled session due to illness, you may request the clinician use that time to work on any of the following and you will be billed at the clinician's full hourly rate:

- parent training, phone consultation, email messages, written documentation (including progress reports and other forms of written communication), written or verbal communication with 3rd party

- payers (including insurance carriers, Community Centered Boards, etc.), creation of individualized therapy materials such as books or stories, record review, other services a client may request.

This agreement shall be construed to harmonize with any network provider agreements between Emerge and any payer of benefits.

I, the undersigned, agree that in consideration of the services to be rendered for the above-named client, the client, his or her parents (if the client is a minor), guardian, conservator, legal representative or agent are obligated to pay Emerge, PC for the services rendered as set forth above. The undersigned acknowledges that he/she has proper legal authority as parent, spouse, guardian, conservator, legal representative or agent to enter into this agreement.

_____ _____

Client's Signature (or Parent/Guardian) **Date**

_____

Printed Name

Assignment of Benefits

If you have any questions about this policy, please ask the Office Manager for assistance before you sign this document.

In consideration for the treatment provided by Emerge, I hereby assign and transfer to Emerge all of the client's right, title and interest in and to for payment for any and all medical, evaluation, behavioral, therapy or other services provided pursuant to insurance or any other health and accident benefit program, whether purchased by the client or another responsible party or provided to the client by any organization or entity. This assignment of benefits allows Emerge to be paid directly by my health insurance carrier or any other health benefit plan for the services Emerge provides to me, my minor child, or to other persons entitled to health care benefits for which Emerge has provided services. This assignment of benefits shall not be construed as an obligation of Emerge to submit claims related to the services provided or pursue any such right to benefits or any other recovery. In no event will Emerge retain benefits in excess of the amount owed to Emerge.

I authorize Emerge to release necessary confidential medical information contained in my medical record to any financial sponsor, insurance company, or managed care company of the client's as may be required for payment to be made on the client's account for services rendered. I understand this authorization for release of information can be revoked in writing at any time.

To the extent possible and necessary, the undersigned will cooperate with Emerge by providing information necessary to obtain payment from any insurer or other benefit plan that may be liable for payment of services provided by Emerge. **Additionally, the undersigned agrees to promptly provide information regarding any change in health benefit coverage.**

Client Acceptance: I have read and understand the above and agree to accept responsibility for all amounts due as described above.

_____ _____ _____

Client's Printed Name **Client's DOB:** **Date**

_____ _____

Client's Signature (or Parent/Guardian) **Parent/Guardian Name (***if applicable***)**

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Client's Name (please print) _____ Client's DOB _____

Client's Rights Acknowledgement – Child or Minor

During the treatment or evaluation process you and your child will be working with a team of professionals from several disciplines. Emerge, P.C. does provide training to students in psychology, education and other service fields. You and your child may receive some services from a trainee supervised by one of our staff members.

There is a state regulatory agency which governs practice by both licensed and unlicensed psychologists in Colorado. If you have any questions or complaints about the psychological services you and your child receive, you have the right to contact the Mental Health Occupations Grievance Board, 1525 Sherman St, Rm 128, Denver, CO, 80203 (303.866.3248). You are entitled to information about the methods and techniques used in evaluation, treatment and fee structure. Also, you may always seek a second opinion or end the process at any time. In a professional relationship, sexual intimacy is not appropriate and should always be reported to the Grievance Board.

I understand as a client of Emerge, PC, my child and I have rights and responsibilities involved with my treatment. I have received a copy of the Emerge Client Rights & Responsibilities form, and I understand we also have rights and responsibilities as outlined in the Emerge Mandatory Disclosure Statement and our clinician's Mandatory Disclosure Statement.

Parent/Guardian Signature _____ **Date** _____

Consent for Evaluations and/or Treatment – Child or Minor

_____ (*name of client*), may have a condition requiring evaluation and/or treatment. As this child's parent/guardian, I apply for and consent to evaluation and/or treatment, such as routine diagnostic procedures. The staff of Emerge, P.C. will also collect background, environmental and socioeconomic information. Information my child and I provide is confidential as are any medical records. Only persons authorized by myself can have access to said records, except as required by law. I understand that I can revoke this consent for treatment, in writing, at any time.

Parent/Guardian Signature _____ **Date** _____

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Client Rights & Responsibilities

In the course of care, a client has both rights and responsibilities. Clients have the right to:

- Be treated with respect and recognition of their dignity and right to privacy
- Receive care that is considerate and respects their personal values and belief system
- Personal privacy and confidentiality of information
- Receive information about their insurance carrier's services, practitioners, clinical guidelines, quality improvement program and consumer rights and responsibilities
- Reasonable access to care, regardless of their race, religion, gender, sexual orientation, ethnicity, age or disability
- Participate in an informed way in the decision making process regarding their treatment planning
- A candid discussion with their treating professionals about appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage
- Participate in treatment planning (if over the age of 12) and have family members participate in such planning
- Individualized treatment, including
    - Adequate and humane services regardless of the source(s) of financial support
    - Provision of services within the least restrictive environment possible
    - An individualized treatment or program plan
    - Periodic review of the treatment or program plan
    - An adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment or program plan
- Designate a surrogate decision maker if they are incapable of understanding a proposed treatment or procedure or are unable to communicate their wishes regarding care
- Be informed, along with their family, of their insurance carrier's rights in a language they understand
- Voice complaints or appeals about their insurance carrier, their provider of care or privacy practices
- Make recommendations regarding their insurance carrier's rights and responsibilities policies
- Be informed of the rules and regulations concerning their own conduct
- Be informed of the reason for any utilization management adverse determination including the specific utilization review criteria or benefits provision used in the determination
- Have utilization management decisions based on appropriateness of care. Their insurance carrier does not reward practitioners or other individuals conducting utilization review for issuing adverse determinations for coverage or service
- Request access to their Protected Health Information (PHI) or other records that are in the possession of their insurance carrier
- Request to inspect and obtain a copy of their PHI, to amend their PHI or to restrict the use of their PHI, and to receive an accounting of disclosures of PHI

Clients are responsible for:

- Providing (to the extent possible) their treating clinician and their insurance carrier with information needed in order to receive appropriate care
- Following plans and instructions for care that they have agreed on with their treating clinician
- Understanding their mental health problems and participating, to the degree possible, in developing, with their treating clinician, mutually agreed upon treatment goals.
- Understanding the Emerge cancellation policy.
- Understanding the Emerge Financial Agreement.

Emerge
Professionals in Autism,
Behavior & Personal Growth

400 South Colorado Blvd, Suite 860, Glendale, CO 80246
Phone: 303.322.9000 – Fax: 303.322.9001
info@emergeprofessionals.com

Insurance/ Third Party Billing Information

Client Name: _____ Client Date of Birth: _____

Insurance Policy Holder's Name: _____

Insurance Policy Holder's Date of Birth: _____

Insurance Policy Holder's Employer: _____

Insurance Company: _____

ID Number: _____

Group Number: _____

Please bring your insurance card with you to your first appointment.

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_____ _____
Client's Name (please print) Client's DOB

RELEASE TO CONTACT THROUGH VOICEMAIL OR WRITTEN CORRESPONDENCE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of the PHI be made to alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Emerge has permission to contact me at the following: (check all that apply)

Home telephone # _____

OK to leave a message with detailed information Yes _____ No _____
OK to leave a message with other family members Yes _____ No _____

Cell Phone # _____

OK to leave a message with detailed information Yes _____ No _____
OK to leave a message with person answering Yes _____ No _____

Work Telephone # _____

OK to leave a message with detailed information Yes _____ No _____
OK to leave a message with _____

Written Communication

OK to mail my home address Yes _____ No _____
OK to mail my work address listed below: Yes _____ No _____

_____
_____
_____

OK to fax to this number: _____

OK to email to this unsecured email address: _____

Other: _____

_____ _____
Client's Signature (or Parent/Guardian of Minor) **Date**

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Standard Consent to Request/Release Medical Information

I, _____
(Parent/Client's Name) First MI Last

Hereby authorize Emerge, P.C. to obtain or release copies of my or _____
Child's Name

medical records from/to:_____
Name of Agency/Organization/Person

_____
Agency/Organization's Mailing Address City/State/Zip

_____ _____ _____
Agency/Organization Phone Fax Email

_____ _____ _____
Client's Date of Birth SSN# Approximate Dates of Treatment

Purpose(s) or need for which information is to be used:

( ) Continuity of Care
( ) Verbal exchange of information only for Continuity of Care (Valid for one year from date of Signature).
( ) Other_____

Specific information to be released:

( ) Psychosocial History
( ) Educational Records/IEP's
( ) Consultations/Intake Summary
( ) Treatment/Individual Service Plan(s)/Behavior Support Plan(s)
( ) Medical Records:
- ( ) Developmental History
- ( ) Neurological History
- ( ) Medication History
- ( ) Other_____

( ) Progress Report(s)
( ) Discharge Summary/After Care Plan
( ) Psychological/Behavioral Evaluations
( ) Other: _____
( ) Physical Examination
( ) Psychiatric History
( ) Laboratory Data

I understand that information to be released may include information regarding the following condition:
( ) Psychiatric Conditions

Authorization

I hereby certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire _____ or if left blank, in 90 days, except in the instance of verbal exchange only for Continuity of Care. I hereby release Emerge, P.C. and its representatives from any liability which may result from furnishing the information requested as authorized in this release.

A copy of this authorization is to be considered as valid as the original.

_____ _____
Client Signature **Date**

_____ _____
Signature of Parent/Legal Guardian (of minor) **Date**