Melissa Thingvoll MD PLLC
100 District Dr. Suite 218
Asheville NC 28803
Phone: (828)774-5068 FAX: (828)575-5448

New Patient Intake Form (To Be Completed by Parents)

Demographic Information

Child's Name: Last_______________________________ First__________________ ☐Male ☐Female
Preferred Name__________________________________ Date of Birth _______/______/________
Address ____
City _____________________________ State ______________________ Zip__________________

Parent Info (please indicate primary contact)

Mother/Legal Guardian ☐primary contact
Name ____ Email Address ____________________________
Address (If Different Than Above) ____
City _____________________________ State ______________________ Zip __________________
Home Phone ____________________ Cell Phone _______________________
Employer ____________________________________ Work Phone _____________________________

Father/Legal Guardian ☐primary contact
Name ____ Email Address ____________________________
Address (If Different Than Above) ____
City _____________________________ State ______________________ Zip __________________
Home Phone ____________________ Cell Phone _______________________
Employer ____________________________________ Work Phone _____________________________

Emergency/Other Contact
Name ____ Email Address ____________________________
Relationship to Child ____
Address (If Different Than Above) ____
City _____________________________ State ______________________ Zip __________________
Home Phone ____________________ Cell Phone _______________________
Employer ____________________________________ Work Phone _____________________________

Insurance Info

Type ____________________________ Primary Policy Holder____________________ DOB ___/___/___
Insurance ID Number ____________________ Group Number ____________________________________

Referral Concerns

Please check all that apply:

☐Attention Problems ☐Learning/Academic Problems
☐General Developmental Concerns ☐Autism
☐Hyperactivity ☐Behavioral Problems
☐Emotional Concerns

Please provide additional comments ____
____
____
____

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Review of Symptoms/Past Medical History

Does or Has Your Child Have Any of the Following	Yes	No	If Yes, Please Describe
Breathing problems, wheezing	☐	☐	
Chronic ear infections	☐	☐	
Sleep difficulties, problems falling asleep, problems staying asleep, snoring, daytime sleepiness	☐	☐	
Headaches, history of head trauma, concussions	☐	☐	
Dizziness or fainting	☐	☐	
Eating problems, GERD (reflux)	☐	☐	
Poor or excessive weight gain, failure to thrive	☐	☐	
Constipation, loose stools, frequent stomach aches	☐	☐	
Eye/vision problems	☐	☐	
Hearing problems	☐	☐	
Bedwetting	☐	☐	
Seizures, tics, repetitive movements	☐	☐	
Anxiety	☐	☐	
Sadness, depression	☐	☐	
Abuse or neglect	☐	☐	
Genetic/inherited disorders	☐	☐	

Pediatrician_____________________________________ Phone Number____________________________________

Other Medical Specialists

1)______________________________________ Reason____

2)______________________________________ Reason____

3)______________________________________ Reason____

Allergies

☐ Drug____ ☐ None

☐ Other____ ☐ None

Current Medications

Medication	Dose and Frequency	Start Date	Reason/Diagnosis

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Are child's immunizations up to date? ☐Yes ☐No

Does your child take any alternative medications? ☐Yes, please list________________________________ ☐ No

Has your child taken any medications in the past for behavioral or developmental concerns? ☐Yes ☐No

If yes, please list medications, reason for taking and any positive or negative response________________

____

____

____

Pregnancy and Birth History

	Yes	No	Comments
Complications during pregnancy?	☐	☐	
Medications during pregnancy? (please list)	☐	☐	
Did mother smoke cigarettes?	☐	☐	
Did mother drink alcohol?	☐	☐	
Did mother use illicit drugs? (please list)	☐	☐	
Child born full term? (if not, list # of weeks)	☐	☐	
Complications during birth?	☐	☐	
Was delivery a cesarean (c-section)?	☐	☐	
Was the child a twin or triplet?	☐	☐	
Were any birth defects noted?	☐	☐	
Was child admitted to NICU? (If yes, please list reason and length of stay)	☐	☐	
Did child have feeding difficulties?	☐	☐	
Did child have low muscle tone or seizures?	☐	☐	
Did child go home on apnea monitor or oxygen?	☐	☐	
Did child have drug withdrawal?	☐	☐	
Birth Weight pounds ounces			

Social History

Who does the child live with?

☐Both parents ☐Mother ☐Father ☐Legal Guardian (relationship to child______________)

Is child adopted? ☐Yes ☐No

Is child in foster care? ☐Yes ☐No

Please list siblings and ages

1) ____
2) ____
3) ____
4) ____
5) ____

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Does child attend school or daycare? ☐School ☐Home School ☐Daycare ☐No
Name of school___________________________________ Teacher______________________________
Grade____

Recent Family Stressors (check all that apply)
☐Divorce/Separation ☐New living situation ☐Other, please describe__________________
☐Death ☐Foster care ______________________________________
☐New school ☐New sibling

Family History

Has Anyone in the Family Been Diagnosed with the Following?	Yes	No	If Yes, Please List Family Member and Type
Attention problems (ADHD, ADD)	☐	☐	
Learning disabilities (dyslexia, etc)	☐	☐	
Autism/Autism Spectrum Disorder	☐	☐	
Developmental Delay/Mental Retardation	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Bipolar Disorder	☐	☐	
Other Psychiatric Disorders	☐	☐	
Genetic Disorders	☐	☐	
Seizure Disorder (epilepsy)	☐	☐	
Other	☐	☐	

Developmental History

Has your child had any of the following assessments or tests? (check all that apply)

☐Psychological or psychoeducational testing
☐CDSA/Early Intervention (EI) assessment
☐Individual Education Plan (IEP)
☐504 Accommodation Plan
☐Speech Therapy
☐Occupational Therapy
☐Physical Therapy
☐Standardized Achievement Tests
☐Other, please list_________________________________

In order to perform a thorough evaluation of your child, please send copies of the above listed evaluations/tests along with the new patient intake form. If not available, please bring to your appointment.

Was early childhood development normal? ☐Yes ☐No, please describe________________________________
Has the child lost any skills? ☐Yes, please describe____ ☐No

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Please give the age at which the child achieved each skill:

Skill	Age
Smiled	
Rolled over	
Crawled	
Walked alone	
Ran well	
Said mama or dada	
Sat alone	

Skill	Age
Spoke first words	
Fed self with spoon	
Slept through night	
Rode tricycle	
Toilet trained	
Slept through night	
Dress independently	

For school-age children:
What type of classroom is your child in?

☐Regular class
☐Regular class with push-in services
☐Regular class with pull-out services
☐Self-contained class
☐Other, please list____

Does your child receive any services in school?

☐Speech/Language Therapy
☐Occupational Therapy
☐Physical Therapy
☐Special Education
☐Music Therapy
☐Counseling
☐Other, please list____

What are the greatest strengths of this child?____
____
____
____
____

What activities or interests does this child have?____
____
____
____
____

Please comment on any specific behavioral concerns?____
____
____
____
____

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Please comment on any learning or academic concerns?____
____
____
____
____

What are the specific questions you would like addressed during his evaluation____________________________
____
____
____
____

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Financial Policy Consent Form

Please take the time to read and understand the following financial policy, which you will be required to sign prior to your appointment. Please feel free to contact us if you have any questions.

Schedule of Fees

Description	Fee
New Patient Evaluation (typically 70-90 minutes)	$500.00
Follow-up Appointment (typically 20-30 minutes)	$175.00
Formal Developmental Testing	$225.00

Insurance Information

Dr. Thingvoll is currently a participating provider ("in network") with the following insurance plans:

- NC Medicaid
- BCBS of NC
- Medcost
- Crescent
- Healthscope

It is important that you understand your insurance benefits. Your insurance is a contract between you and your insurance provider, and there is no guarantee of benefits. Your insurance company will only pay for services covered under your contract. We urge you to contact your insurance company before your appointment to ask about pre-authorization requirements and coverage for subspecialty developmental pediatric care, including developmental testing (CPT code 96111) in order to reduce the chance of claim denial. In the event that some or all of your services are not covered by your insurance plan, you will be responsible for 100% of these charges at the time of your visit.

If you have one of the above listed insurance plans, we will file the claim on your behalf. Please provide your insurance information on the New Patient Intake Form and bring your insurance card to the first appointment. If you fail to do so, you will be responsible for full payment at the time of your appointment.

Payment

Payment is due in full at the time of your appointment. We accept payment in the form of cash, checks, VISA and Mastercard. There is a returned check fee of $35.00.

For patients with insurance that Dr. Thingvoll is a participating provider, you will required to pay all co-pays, co-insurance, and deductibles at the time of your appointment.

For patients without insurance or with insurance that Dr. Thingvoll is NOT a participating provider ("out of network"), fees will be charged according to the fee schedule above. For these patients, you will be provided with an itemized statement with all of the required information that you can submit to your insurance company for reimbursement. For these patients, we still encourage you to call your insurance company before your appointment to ask about pre-authorization requirements and covered services.

Credit Card Policy

We require a valid credit card to be on file in order to schedule an appointment. This credit card will be used to charge "no show" and "late cancellation" fees (see below) when appropriate. We will notify you at the time we remit these charges. Any balance due after your insurance claim is processed will be billed directly to you. Credit card information will be stored in a PCI (Payment Card Industry Security Standard) compliant database through TransFirst Health. **Please note that Medicaid patients will not be required to have a credit card on file.**

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Missed Appointments (No Shows) and Late Cancellations

Due to the complex nature of developmental pediatric evaluations and the amount of time scheduled for these evaluations, no shows and late cancellations (less than 48 business hours before the scheduled appointment time) will be charged according to the schedule listed below. Charges for no shows and late cancellations will be applied to the credit card on file. **Please note that Medicaid patients will not be charged for missed appointments or late cancellations.** Medicaid patients who do not show up for their appointment will be discharged from the practice and not allowed to reschedule. Medicaid patients who cancel less than 48 business hours before their appointment may be rescheduled at our discretion.

Description	Fee
Missed Appointment/No Show – New Patient	$200.00
Missed Appointment/No Show – Follow-up	$75.00
Late Cancellation (less than 48 hours notice)	$75.00

Unpaid Balances

Should there be a payment balance due to claim denial, uncovered services, or changes to your insurance plan, you will be billed for the balance. Unpaid balances 60 days after sending the bill will be charged to the credit card on file. Should the credit card not be valid, and an alternative payment arrangement not agreed upon, legal means might be used to secure payment, which may include hiring a collection agency.

Phone Consultation and Other Services

We provide telephone care free of charge to answer routine questions regarding the evaluation and treatment of your child, including prescription refill requests, medication dosage questions/adjustments, medication side effects, follow-up on any test results, referrals or other basic questions.

Occasionally, there is a need for more involved, complicated telephone consultation that requires physician expertise and time as well as clinical documentation. These services are billable and not covered by insurance companies. Other billable services include the completion of school, medical and legal forms and writing school, medical or legal letters. Results of your evaluation will be faxed to the referring provider and mailed to the parent/guardian. Additional copies of the medical record require a nominal fee. These services are billed after the encounter according to the schedule below. Please note that the charge for these services will include documentation time.

Description	Fee
Physician Phone Consultation (longer than 5 minutes)	$25.00 per 10 minutes
Completion of Any Forms or Writing Letters	$25.00 per 10 minutes
Additional Copies of Medical Record (includes shipping)	$10.00
Other Services Not Listed	Negotiable, typically $25.00 per 10 minutes

Acknowledgement

By signing below, you acknowledge that you have read, understand and agree to abide by the terms of this policy. This includes your consent to have your credit card on file charged according to the terms of this policy.

____ ______/________/_________

Child's Name: Last First Date of Birth

____ ______________________

Signature of parent/legal guardian Date signed

____ ______________________

Printed name of person signing financial policy Relationship to

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: ____ Date of Birth: ________________

Parent's Name: ____ Parent's Phone Number: ______________________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ____________ Child's Name: ______________________________ Date of Birth: ______________

Parent's Name: ______________________________ Parent's Phone Number: ______________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ____________

Total number of questions scored 2 or 3 in questions 10–18: ____________

Total Symptom Score for questions 1–18: ____________

Total number of questions scored 2 or 3 in questions 19–26: ____________

Total number of questions scored 2 or 3 in questions 27–40: ____________

Total number of questions scored 2 or 3 in questions 41–47: ____________

Total number of questions scored 4 or 5 in questions 48–55: ____________

Average Performance Score: ____________