Melissa Thingvoll MD PLLC
100 District Drive, 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 (please fill in all insurance information, including ID number)

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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Does child attend school or daycare? ☐School ☐Home School ☐Daycare ☐No

Name of school_____
Teacher(s)_____
Grade_____
School Phone _____ School FAX _____

☐ By checking this box, you authorize Dr. Thingvoll to send educational forms to your child's school to be filled out by his/her teacher(s), which will provide valuable information for a complete evaluation.

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

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

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Current Medications

Medication	Dose and Frequency	Start Date	Reason/Diagnosis

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

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Please list siblings and ages

1) _____
2) _____
3) _____
4) _____
5) _____

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.

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

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 this evaluation_____
_____
_____
_____
_____

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Patient Receipt of Notice of Privacy Practices (HIPAA)

Child's Name: Last_____ First_____

Date of Birth _____/_____/_____

Dr. Thingvoll is committed to maintaining the integrity of your protected health information and complies with all state and federal regulations according to the Health Insurance Portability and Accountability Act (HIPAA) of 2003. A copy or our HIPAA policy is available on our website at ashevillebehavior.com. According to HIPAA:

1) You are not required to sign the acknowledgement in order to receive services/treatment.
2) Signing the acknowledgement does not mean that you have agreed to any special uses or disclosures of your protected health information.
3) Refusing to sign the acknowledgement does not prevent the provider from using or disclosing your protected health information as HIPAA permits it to do.
4) If you refuse to sign the acknowledgement, the provider must keep a record that they failed to obtain your acknowledgement.

Receipt of Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices (HIPAA) with detailed information about how Dr. Thingvoll may use and disclose my protected health information. I understand that Dr. Thingvoll reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____
Signature of parent/legal guardian Date signed

_____ _____
Printed name of person signing release Relationship to child

Office Use Only: To be completed only when a patient declines to sign acknowledgement

☐ Patient declined to sign acknowledgement

Staff signature_____ Date_____

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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)	$600.00
Follow-up Appointment (typically 20-30 minutes)	$165.00
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

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

Revised - 1102

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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: _____

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ
National Initiative for Children's Healthcare Quality

McNeil
Consumer & Specialty Pharmaceuticals