info@mailppa.com
www.SouthFloridaTherapists.com
(305) 936-1002 (305) 936-1022
South Florida & New York Tri-State Area
Telepsychology Across PSYPACT States

Dear Patient/Parent/Caregiver:

Welcome to our practice. Attached are several forms to fill out and sign to help us gather information regarding you and your family. Also enclosed are documents containing summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The law requires that we provide you with a Notice of Privacy Policies (which is attached) and obtain your signature acknowledging that we have provided you with the information.

We encourage you to complete these forms prior to your first appointment and forward to info@mailppa.com or fax to (305) 936-1022. If you are unable to, please bring them to your first appointment.

Every member of our professional and support team has been chosen for their caring attitudes as well as their professional credentials. If you should have any questions, do not hesitate to contact us.

Warmest Regards,

Pediatric Psychology Associates

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EARLY CHILDHOOD DEVELOPMENTAL HISTORY FORM

Child's Name:_____Date:_____

Age:_____Date of Birth:_____Birthplace:_____

Home Street Address:_____

City: _____State:_____Zip Code:_____Home Phone:_____

Email Address(es):_____

Who does your child live with? (*check one*): ☐ Biological ☐ Adoptive parents
Is your child living with both parents? ☐ Yes ☐ No

If parents are living apart (separated or divorced) is other parent aware that you are seeking psychological services for your child? ☐ Yes ☐ No

Please list other Parent's information:

Name and Best Contact Number:_____

Home Street Address:_____

City: _____State: _____Zip Code: _____

How were you referred to our office?_____

Phone number of referral source_____

Do you have any concerns about your child at this time? ☐ Yes ☐ No If yes, please explain:

FAMILY INFORMATION

Parent 1 Name:_____Age:_____Birthdate:_____

Occupation:_____Education:_____

Cellular:_____Email:_____

Parent 2 Name:_____Age:_____Birthdate:_____

Occupation:_____Education:_____

Cellular:_____Email:_____

If child is not living with both biological/adoptive parents, describe living/visitation arrangements:

_____

_____

Siblings

Name	Gender	Age	School/Occupation

Other Persons in the Home

Name	Age	Relation

DEVELOPMENTAL AND HEALTH INFORMATION

Pediatrician's Name:_____Phone :_____

Date of last medical check-up?_____What were the findings?_____

_____

Height:_____Weight:_____Medication taken at this time:_____

What is your child's present health? ☐ Excellent ☐ Good ☐ Fair

Please explain:_____

Is there a history of ear infections? ☐ Y ☐ N If yes, list frequency_____

Does your child have allergies? ☐ Y ☐ N If yes, what kind?_____

Has your child ever had any head injuries (loss of consciousness), seizures, hospitalizations or surgery? ☐ Y ☐ N If yes, please explain:_____

Approximate weight at birth:_____Weeks Carried:_____Type of Delivery:_____

Mother's age at delivery:_____Health during pregnancy:_____

Describe any complications during pregnancy or birth:_____

_____

Describe your child's health during and after delivery:_____

_____

Did your child require extended hospitalization following birth (i.e., NICU)? ☐ Y ☐ N

Check the items that apply to your child's behavior as an infant:

☐ Frequently smiled	☐ Easy to soothe	☐ Frequently cried
☐ Difficult to soothe	☐ Cried when wet	☐ Enjoyed being held
☐ Enjoyed being rocked	☐ Difficulty with novelty	☐ Adapted easily to new situations

Check the items that apply to your child's behavior as a toddler (if applicable):

☐ Independent	☐ Talkative	☐ Angry
☐ Fearless	☐ Overactive	☐ Daring
☐ Stubborn	☐ Compliant	☐ Quiet
☐ Curious	☐ Aggressive	☐ Adaptable
☐ Distractible	☐ Friendly	☐ Defiant
☐ Affectionate	☐ Easy to discipline	

*Is your child doing the following? If so, please give approximate **AGES** when he/she:*

Motor	**Language**
Sat up_____	Said first word_____
Crawled_____	Babbling_____
Walked_____	Talked in sentence_____

How many words is your child using at this time?_____

If he/she is not yet verbal, how does he/she communicate needs?_____

_____

Does your child use gestures to communicate (e.g., wave bye-bye, point, blow kisses)?_____

What language(s) does your child speak and which is primary?_____

What language(s) are spoken in the home and which is primary?_____

Feeding

Is (was) your child bottle/breast fed? ☐ Y ☐ N If breast fed, until when? _____

Does he/she use a pacifier? ☐ Y ☐ N Is your child toilet trained(ing)? ☐ Y ☐ N

Does your child eat solid foods? ☐ Y ☐ N Can he/she eat independently? ☐ Y ☐ N

Finger foods or utensil? (*Circle one)*

Where does your child sleep?_____Describe bedtime routine:_____

_____

Please mark any areas which constitute a problem for your child:

- ☐ Eating
- ☐ Sleeping
- ☐ Nightmares
- ☐ Thumb sucking/Mouthing objects
- ☐ Interest in peers
- ☐ Self-help skills (feeding, etc.)
- ☐ Excessive drooling

Has your child ever had a developmental evaluation? ☐ Y ☐ N If yes, date(s)_____

Agency or name of doctor/therapist(s):_____

Has your child ever received speech, occupational or physical therapy? ☐ Y ☐ N

If yes, date(s) and which services?_____

Agency or name of therapist(s):_____

By whom is your child cared for during the daytime?_____

List schools your child has attended (include nursery/daycare if applicable):

Name	City	Age(s)	Reason for Leaving

Describe behavior in daycare:_____

SOCIAL AND EMOTIONAL INFORMATION

What does your child enjoy doing? How do you know he is enjoying this activity?_____

_____

Share any extracurricular activities (Gymboree, Mommy & Me, Music) that your child is enrolled in:

_____

Do you feel your child is having difficulties in daycare? ☐ Y ☐ N At home? ☐ Y ☐ N

If so, what do you consider the problem to be and when and how did it begin?_____

_____

Describe any unusual fears:_____

Are there any past or present circumstances which you think could be related to your child's present difficulties?_____

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? ☐ Y ☐ N If yes, please describe_____

_____

Is there any family member (sibling, parent, grandparent, etc.) who presently or in the past have experienced the following (*check those that apply*):

_____Learning difficulties _____Attention difficulties _____Behavior difficulties
_____Special classes _____Developmental delay _____Speech delay
_____Emotional difficulties (e.g., depression, anxiety)

If yes, who and what kind/type? _____

History of physical or sexual abuse, family violence or neglect? ☐ Y ☐ N

If yes, please explain_____

Please list some of your child's strengths?_____

_____

Please list some of your child's weaknesses?_____

_____

Please put any other comments that will help me understand your child better_____

_____

What are your goals/expectations from this evaluation?_____

_____

Consent for Treatment

I voluntarily agree to and give consent for treatment by Pediatric Psychology Associates/MDDC for myself and/or my family members.

Signature_____Date_____

Print Name_____Relation to child_____

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Payment Responsibility and Agreement

Name of Patient:_____

At Pediatric Psychology Associates, our mission is to deliver exceptional care and meet the needs of our clients. To support continuity of care and provide clarity on our financial and scheduling policies, we kindly ask you to review the following guidelines:

Financial Responsibility

- Payment is required at the time of service unless prior arrangements have been made.
- The responsibility for payment of psychological services provided by PPA rests solely with the patient (caregiver/guardian if the patient is a minor).
- Patients are responsible for their scheduled appointment time, regardless of whether or not a courtesy email/text reminder of the appointment was sent.
- Consultation/Treatment Sessions: Standard consultation and treatment sessions are 45 minutes. Extended (60-minute) and double (90-minute) sessions are available and billed at a prorated rate based on the standard 45-minute session fee.
- Testing/Evaluation Services: Evaluation fees and payment structures vary depending on the specific service provided. *Please refer to the Deposit and Cancellation Policies for Testing/Evaluation Services* below.
- Additional Charges:
    - Charges for additional professional services, such as extended phone or email communications (over 10 minutes), consultations with other professionals (with your consent), preparation of records, written letter requests, treatment summaries, and other services requested outside of standard sessions, will be billed in 15-minute increments at a prorated rate based on the standard 45-minute session fee.
    - Services provided outside the office, including home/school visits or team meetings, may incur travel fees, which would be discussed with the patient in advance.
    - If professional services are required for legal matters (e.g., depositions, testimony, attorney consultations, or completing forms that require professional opinions), legal/forensic fees and policies will apply. Such details would be discussed with the patient at the time of inquiry/request for services.

Cancellation Policy for Consultation/Treatment Services

- **24-Hour Notice Requirement**: In the event a scheduled appointment needs to be cancelled, a minimum of 24 hours' notice is required. Appointments cancelled with less than 24 hours' notice are considered **Late Cancellations/No-Shows.**

- **New Patients:** Please note that new patients who do not provide 24-hour notice of cancellation or fail to attend their initial appointment will be required to submit all history documents, consents, and a credit card authorization form, with payment made in advance, before their appointment can be rescheduled.
- **Late Cancellations/No-Shows:**
    - For the first no-show or late cancellation a $100 fee will be assessed.
    - All subsequent no-shows or late cancellations will be charged at the full session rate. For extended sessions (60-90 minutes) and testing appointments, the time reserved will be billed.
    - Late cancellations/No-Shows due to illness require a doctor's note within 72 hours to waive charges. Charges will be applied but reversed upon receipt of the note.
    - If a patient becomes ill on the day of an in-office appointment, we ask to be notified as soon as possible. To ensure continuity of care and avoid fees for missed sessions, patients will be offered the option to convert the in-person appointment to a telehealth session with the patient and/or caregiver.
    - Emergencies eligible for fee waivers include critical hospitalization of a family member, family crises (e.g., a death), natural disasters, or accidents preventing attendance or timely cancellation. Documentation may be required, and each case will be individually reviewed.
- **Excessive Cancellations/No Shows & Recurring Appointments:**
    - After three (3) no-shows or late cancellations, therapy services may be terminated. If services are resumed, a credit card will be required to be kept on file and charged at the time the appointment is scheduled. Any future cancellations must be made more than 48 hours in advance to avoid termination of services.
    - If you frequently cancel a recurring (standing) appointment, even with advance notice, we may need to release your spot. Regular attendance is important to ensure scheduling runs smoothly and to allow other families the opportunity to utilize available times.

Office Cancellation Procedure:

- To cancel an appointment, patients must contact the **office via text or call (305) 936-1002 or email to appointments@mailppa.com**. If you are calling after hours or unable to reach our front desk team, please leave a detailed voicemail. While our phone system tracks all incoming calls and can verify the number, providing a clear message is essential to ensure your therapist is notified promptly and the necessary steps for rescheduling or follow-up care can be taken.
- While you may choose to email or text your provider directly, they are often in sessions and may not respond promptly. Therefore, it is crucial to cancel directly with the office, especially if the notice is given less than 24 hours before the appointment.
- Please note our automated email appointment reminders do not accept replies

Deposit and Cancellation Policies for Testing/Evaluation Services

Testing services require our clinicians to allocate multiple hours and at times coordinate schedules with other members of our team. Given scheduling complexities and level of commitment from our clinical team, we have established the following deposit and cancellation policies. These policies support smooth scheduling and availability for all patients, and ensure that our patients receive the full benefit of our services.

- **Deposit:**
    - For testing/evaluation services that are completed in one session, deposit of 50% of the total evaluation cost will be collected at the time the testing appointment is scheduled. This includes but is not limited to the following services (gifted, ADOS only, MDDC, school entrance, as well as any evaluation that is completed in one

session).This deposit will be applied towards the total balance due at the time services are rendered.
    - If multiple testing sessions are requested to be reserved in advance prior to the initial consultation, a deposit of 50% of the total evaluation cost will be collected at the time the appointments are scheduled.
- **Cancellations:**
    - For appointments that required a 50% deposit fee (single day testing or advanced scheduling):
        - Cancellations with More than 72 Hours' (3 business days') Notice: Evaluation appointments cancelled with more than 72 Hours' Notice (3 business days) will be eligible for a full refund of the deposit.
        - Cancellations with less than 72 Hours' (3 business days') Notice but More than 24 Hours' Notice: For evaluation appointments cancelled with more than 24 hours' notice but less than 72 hours' (3 business days) notice, the deposit will not be eligible for refund, but could be applied to a future, rescheduled appointment.
        - Cancellations with Less Than 24 Hours' Notice or No-Shows: If the scheduled testing appointment is cancelled with less than 24 hours' notice or missed without notice, the deposit will not be refunded. Exceptions would only include cases of emergencies or exceptional, documented circumstances, such as illness supported by a doctor's note. In the absence of such circumstances, the deposit is forfeited, and an additional 50% deposit will be required to reschedule the missed appointment(s).
    - For testing appointments that are cancelled with less than 24 hours' notice that have had an Initial Consultation and are completed over several sessions, the time reserved will be billed (at the consultation rate) for any scheduled appointment that is cancelled with less than 24 hours' notice.
- **Excessive Cancellations/No Shows:**
    - After three (3) Late Cancellations/No-Shows or Cancellations (regardless of the cancellation reason), testing services may be terminated. If services are resumed, a credit card will be required to be kept on file and charged at the time the appointment is rescheduled.

Thank you for your understanding and cooperation. These policies help us provide the best possible care to you and all of our clients. If you have any questions or need further clarification, please do not hesitate to contact our office.

Patient/Parent/Guardian Signature:_____

Printed Name of Signer:_____ Date:_____

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HIPAA Notice of Privacy Practices- Effective Date: January 1, 2025

Pediatric Psychology Associates (PPA) is committed to protecting the privacy and confidentiality of your health information. This notice describes your rights under the Health Insurance Portability and Accountability Act (HIPAA) and explains how we may use and disclose your Protected Health Information (PHI). Please review this document carefully.

How We May Use and Disclose Your Information:

- **For Treatment:** We may share your PHI with other healthcare providers involved in your care to ensure you receive the best possible treatment.
- **For Payment:** We may use and disclose your PHI to process payments for services, such as submitting claims to insurance companies.
- **For Healthcare Education:** PHI may be used for quality improvement activities and other operational purposes within Pediatric Psychology Associates.
- **Required Disclosures:** We are required to disclose your PHI in certain circumstances, such as reporting abuse, neglect, or imminent danger to the appropriate authorities. We are also required your PHI to disclose if request by law enforcement or a court order/subpoena.
- **Authorized Disclosures:** We will not share your PHI with other family members, friends, or other third parties without your written consent, except in situations permitted or required by law.

Your Rights and Responsibilities - As a Patient/Parent/Guardian, you have the following rights and responsibilities regarding your PHI:

- **Access to HIPPA Notice:** You are entitled to a paper or electronic copy of this notice upon request.
- **Access to Medical Records:** You have the right to access and obtain a copy of your health records. You may request amendments to your health information if you believe it is inaccurate or incomplete.

- **Communications:** You may request to receive communications about your PHI.
- **Restrictions:** You may request that we restrict certain uses and disclosures of your PHI. While we will consider your request, we are not required to agree to all restrictions.
- **Accuracy of Information:** You must ensure the information you provide about your health history is complete and accurate. Notify us of any changes to your address, phone number, or other contact details. Please note that we encourage open communication regarding the potential need to share information with designated emergency contacts in critical situations.

PPA reserves the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you, provided those changes affect your health information.

If you have questions or concerns about this notice or your privacy rights, please contact us:

Pediatric Psychology Associates - 305-936-1002 or info@mailppa.com
Mailing Address: 2925 Aventura Blvd, Suite 300, Aventura, FL 33180

Acknowledgment of Receipt

I acknowledge that I have reviewed the HIPAA Notice of Privacy Practices provided by PPA (and can obtain a copy when requested).

Name of Patient: _____

Patient, Parent or Guardian Signature:_____ Date:_____

If refused, reason for refusal:_____

Restrictions noted:_____

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Telehealth Policies and Procedures

Pediatric Psychology Associates (PPA) provides Telehealth Services when appropriate. This document has procedures for those services along with important information about PPA's Telehealth Policies. ***Please read this document completely and save it for your records.***

1. **Platform:** PPA uses RingCentral (a HIPAA compliant platform) for its Telehealth Sessions. RingCentral is accessible through a web browser on your computer and/or a free app download. You will be provided a link to use to connect to your Telehealth session in advance of your sessions.

2. **Disconnections:** In the case of a disconnection during your telehealth session, please attempt to reconnect. If it is not possible to reconnect, please call the office at 305-936-1002. Your therapist may opt to continue your session by phone or to reschedule.

3. **Etiquette and Location of Telehealth Sessions:** The convenience of telehealth sessions along with our tendencies to multitask while communicating via technology often leads patients to see telehealth sessions differently than an in-office visit (e.g. try to get their session done "on the go" or while doing other things). Approaching a telehealth session in this manner frequently leads to distractions, interruptions during the session, loss of privacy, and an overall reduction in efficacy of treatment. **It is very important that you treat your telehealth session just the same as an in-office visit.** That means that you will need to be in a quiet, private place that is free of distractions and interruptions. You should close all other applications and put your devices on silent or "do not disturb" mode so you can give 100% of your focus to your session. You should also be sitting upright in a seat (as opposed to lying down in bed or on a couch, walking around, etc.) **If at the time of your session your therapist finds that you are not in a suitable location for the appointment, he/she may choose not to continue with the session, at which point the session will be treated as a no-show/late cancellation.**

4. Patients agree to refrain from recording, photographing, reproducing, publishing or otherwise maintaining copies of sessions.

5. Because you are not physically in an office to remit payment, arrangements for payment for Telehealth Sessions will be made in advance of the session.

6. If you are receiving Telehealth Services, it is essential that we have a plan for emergencies. You are required to provide the following information along with consent to contact and communicate with these parties, including sharing health care information if deemed necessary:
    a. Name and contact information of an emergency contact person who can help in case of a crisis.
    b. Name and phone number of the closest emergency room to your location.

If you have any questions regarding our Telehealth Policies and Procedures, please do not hesitate to discuss them with your therapist.

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Telehealth Services Agreement and Informed Consent

I _____ (Patient/Guardian name) hereby consent to participating in Telehealth Services with Pediatric Psychology Associates (PPA).

Telehealth services are defined as communication between yourself and our organization via telephone, email, text message, video conferencing, or any other remote means that utilizes electronic transmitting technology. This includes what is defined as "teletherapy" (psychotherapeutic intervention done remotely via videoconferencing or telephone), as well as use of technology for administrative purposes (e.g. emails and phone calls regarding scheduling appointments). I understand that Telehealth allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment. This Consent Form covers all forms of electronic communication (teletherapy and administrative).

1. I have a right to confidentiality with telehealth services under the same laws that protect the confidentiality of my medical information for in-person psychotherapy, as noted in PPA's Informed Consent Form.

2. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective, and this includes Telehealth Services.

3. I understand that Telehealth Services risk technological failure that could cause distortion or complete disruption.

4. I have the right to withhold or withdraw this consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

5. I understand that PPA uses HIPAA compliant methods for Telehealth Services. However, no use of technology can be 100% protected. I also understand that the confidentiality of any text messages, emails, or voicemails I choose to keep is my responsibility and not the responsibility of PPA.

6. I consent to my provider contacting my emergency contact or local emergency services if a situation arises that requires immediate intervention. This may include sharing private healthcare information if deemed necessary.

Emergency Contact Person	**Local Emergency Services**
Name:	Nearest Hospital Name:
Relationship to Patient:	Phone:
Phone:	

I acknowledge that I have read and understand this important information regarding Telehealth Services.

_____ _____ _____

Patient/Guardian Printed Name Patient/Guardian Signature Date

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No Surprises Act- Good Faith Estimate of Costs

The purpose of this document is to let you know that PPA is an out-of-network provider with all insurance plans. If you prefer to use your health insurance, we would advise you contact your insurance company for a list of in-network providers. PPA does not accept insurance assignment, which means fees are not collected from insurance companies, rather they are paid directly by the responsible party. If you choose to submit to your insurance company the services you receive from PPA, your insurance may not cover some or all of the services.

With regards to an estimate of fees that will be paid for psychological services rendered, this will depend on the severity, duration, and diagnosis of the individual. Treatment length is variable and depends on numerous factors including how long the difficulties have been present. Current fee rates at PPA as of 1/1/2023, for Individual/Family Psychotherapy fees for a 45-minute session ($210 Master's Level and $300 Doctoral Level) and group psychotherapy is $90 a session. Fees are also reflected on our website at www.SouthFloridaTherapists.com. If fees change, you will be notified in advance. There may be additional items or services that are recommend as part of the treatment that will be scheduled separately and are not reflected in this good faith estimate. The information provided in this good faith estimate is only an estimate and actual items, services, or charges may differ from this good faith estimate. Nevertheless, you and your family members are free to discontinue treatment at any time. You can cancel sessions with 24 hours advance notice to avoid a fee.

If you have any questions or objections to any charge, please let the office know immediately. If unexpected costs arise, Federal law allows you to dispute the bill. You may start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There may be a small fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 800-985-3059.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care. This is not a contract and you are not required to obtain any services from PPA. However, if this is not signed, PPA is not able to provide and/or continue therapeutic care to you and/or your family members. If you have any additional questions, please direct them to your provider.

I understand and accept the above:_____ (signature)

Name of Patient/Responsible Party:_____ Date:_____