Waseem Alhushki, MD
Kanyalakshmi Ayyanar, MD
Danielle Bello, PhD
Angela Berg, DNP, CPNP
Diane Brown, MD, PhD

CURE 4 THE KIDS FOUNDATION

Jennifer Buitrago, APRN, CPNP
Alan Ikeda, MD
Joseph Lasky, MD
Nicola Longo, MD, PhD
Katherine Marzan, MD
Nik Abdul Rashid, MD

Welcome to the offices of Cure 4 the Kids Foundation. We appreciate the confidence and trust that you have placed in our office and look forward to meeting you personally and professionally. Our goal is to provide the highest quality care in a friendly, caring and efficient environment.

We have enclosed our new patient paperwork for your convenience. Please return the completed forms and a copy of your insurance card several days in advance of your office appointment. This will allow our staff the opportunity to process this information into our data system. We hope to provide timely visits and correspondence with your physicians.

We ask that you bring the following items to our office for your first visit:

- Current insurance card & Driver's license or government issued photo ID
- Recent school report cards and if available, special education documents (IEP or 504 Plan)

Please check in at **the 3rd Floor** of our Las Vegas office located at One Breakthrough Way, Las Vegas, NV 89135 (closest intersection is 215 and Town Center Dr.).

Should you have any questions or need any additional information please don't hesitate to call our office at 702-732-1493.

We look forward to seeing you at our office. Thank you for giving us the opportunity to serve you.

Sincerely,

The Staff of Cure 4 the Kids Foundation

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Patient Registration & Insurance Information

Please verify patient's information and change if incorrect. The front desk is available if you have any questions.

PATIENT INFORMATION

PATIENT NUMBER		**DATE**			
PATIENT LAST NAME	**FIRST NAME**	**MIDDLE INIT**	**SSN**		**SUFFIX**
ADDRESS 1		**CITY**	**STATE**	**ZIP**	
HOME TEL #	**WORK TEL #**	**CELL #**	**SEX**	**AGE**	
BIRTHDATE	**EMPLOYER**	**E-MAIL ADDRESS**			
USUAL PROVIDER	**REFERRING PHYSICIAN** «RFName»	**PRIMARY CARE PHYSICIAN** «PCPName»			
MARITAL STATUS	**EMPLOYMENT STATUS** ☐ Full ☐ Part ☐ Retired ☐ Unemployed	**STUDENT STATUS** ☐ Full Time ☐ Part Time ☐ Not a Student	**REL TO GUARANTOR**		
ETHNICITY *(select 1)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Refused	**LANGUAGE** ☐ English ☐ Spanish ☐ _____	**INTERPRETER NEEDED** ☐ Yes ☐ No			
RACE *(select 1)* ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Japanese ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Unknown/Refused					

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)

GUARANTOR LAST NAME	**FIRST NAME**	**MIDDLE INIT**	**SSN**	**SUFFIX**
ADDRESS 1	**CITY**	**STATE**	**ZIP**	
HOME TEL #	**WORK TEL #**	**CELL #**	**SEX**	**EMERGENCY CONTACT** ☐ Yes ☐ No
BIRTHDATE	**EMPLOYER**	**E-MAIL ADDRESS**		

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
CARRIER NAME		**CARRIER NAME**	
CARRIER ADDRESS		**CARRIER ADDRESS**	
CERTIFICATE ID #		**CERTIFICATE ID #**	
GROUP NAME		**GROUP NAME**	
CLAIM/GROUP NO		**CLAIM/GROUP NO**	
CARRIER PHONE #		**CARRIER PHONE #**	
SUBSCRIBER NAME		**SUBSCRIBER NAME**	
SUBSCRIBER D.O.B.		**SUBSCRIBER D.O.B.**	
SUBSCRIBER SSN		**SUBSCRIBER SSN**	
RELATIONSHIP TO PATIENT		**RELATIONSHIP TO PATIENT**	

EMERGENCY CONTACT INFORMATION

1	**EMERGENCY CONTACT #1**			**SUFFIX**
	PHONE #1	**PHONE #2**	**PHONE #3**	**RELATIONSHIP TO PATIENT**
2	**EMERGENCY CONTACT #2**			**SUFFIX**
	PHONE #1	**PHONE #2**	**PHONE #3**	**RELATIONSHIP TO PATIENT**

CURE 4 THE KIDS FOUNDATION

Psychological History Questionnaire – Parent

Today's Date: _____

Child's Name: _____

Date of Birth: _____ Age: _____ Grade: _____

School: _____ Classroom: Regular ☐ Other ☐

Your Name: _____ Relation to Child: _____

What are your primary concerns you have for your child at this time? _____

_____

_____

_____

FAMILY HISTORY

Are you aware of anyone on either the biological (natural) mother's or father's side of the family who has had any of the following problems? (Please check all that apply)

	Mother's side	Father's side
1. Seizure disorder	☐	☐
2. Reading problems	☐	☐
3. Spelling problems	☐	☐
4. Arithmetic problems	☐	☐
5. Early speech or language problems	☐	☐
6. Motor incoordination	☐	☐
7. Drug or alcohol abuse	☐	☐
8. Depression	☐	☐
9. Bipolar Disorder	☐	☐
10. Mental retardation	☐	☐
11. Psychosis; Schizophrenia	☐	☐
12. Mental hospitalization	☐	☐
13. Hyperactivity/restlessness/fidgetiness	☐	☐
14. Motor or vocal tics	☐	☐
15. Problems paying attention/concentrating	☐	☐
16. Anxieties/fears/phobias	☐	☐
17. Significant shyness	☐	☐
18. Significant mental illness	☐	☐
19. Autism or Asperger's Disorder	☐	☐
20. Criminal activity	☐	☐
21. Other significant behavioral/emotional problems	☐	☐

Please explain any items checked: _____

_____

_____

CURE 4 THE KIDS FOUNDATION

FAMILY RELATIONSHIPS

Please list the members of the child's current household:

Full Name	Relationship to Child	Age

Please list other relatives not living with the child (i.e., biological or step parents or siblings; grandparents; etc.):

Full Name	Relationship to Child	Age

Has your child recently experienced any significant family-related stress or change (e.g. death of a loved one, a recent move, illness in a family member, significant conflict, birth of a sibling, etc.)? ☐ Yes ☐ No

If yes, please explain the stress/change and how your child reacted to it: _____

_____

_____

_____

Have there been any other significant family or marital problems? ☐ Yes ☐ No

If yes, how were these problems manifested in the home (e.g., yelling, physical violence, divorce) and how did your child react to the problems? _____

_____

PRENATAL (PREGNANCY) HISTORY

1. Did mother smoke cigarettes while pregnant with this child? ☐ Yes ☐ No
   If yes, how many cigarettes a day on average? _____
2. Did mother drink alcoholic beverages while pregnant with this child? ☐ Yes ☐ No
   If yes, how many days a week on average? _____ How many drinks at a time on average? _____
   What types of alcohol? _____
3. Did mother use illicit drugs while pregnant with this child? ☐ Yes ☐ No
   If yes, which ones? _____
4. Did mother use prescribed medications while pregnant with this child? ☐ Yes ☐ No
   If yes, which medications and why? _____

   _____
5. Did mother have bleeding while pregnant with this child? ☐ Yes ☐ No
   If yes, at what point(s) during the pregnancy? _____
6. Check any medical conditions mother had while pregnant with this child:

☐ prenatal infections	☐ loss of consciousness
☐ prenatal growth problems	☐ emotional problems
☐ high blood pressure	☐ diabetes
☐ low blood pressure	☐ nutritional deficiency
☐ toxemia	☐ other (specify) _____

7. Did any of these problems appear to affect the fetus? ☐ Yes ☐ No
   If yes, which ones and how? _____
   _____
8. Mother's weight gain was considered ☐ low, ☐ normal, ☐ high.

PERINATAL/NEONATAL HISTORY

1. Age of mother at birth of this child: _____
2. Was pregnancy full term? ☐ Yes ☐ No
   If no, was birth between 32-37 weeks of gestation (preterm)? ☐ or fewer than 32 weeks (very preterm)? ☐
3. Birth was ☐ head first, ☐ breech, ☐ cesarean?
4. Birth weight was _____ pounds _____ ounces.
   If exact birth weight is not recalled, was it referred to as low birth weight (under 5 lbs. 8 oz.) ☐ or extremely low birth weight (under 2 lbs. 3 oz.) ☐?
5. What were baby's Apgar scores at 1 minute _____ 5 minutes_____?

INFANCY

1. Was baby in any kind of distress at birth? ☐ Yes ☐ No
   If yes, explain: _____
   _____
2. Did baby require delivery room resuscitation? ☐ Yes ☐ No
3. Was baby placed in Neonatal Intensive Care Unit (NICU)? ☐ Yes ☐ No
4. If yes, for how long? _____ For what reason(s)? _____
   _____
5. Check any medical conditions at birth:
   A. Brain/Central Nervous System
   ☐ Bleed
   ☐ Neonatal Convulsions
   ☐ Spina Bifida
   ☐ Hydrocephalus
   ☐ Tumor
   ☐ Other; please explain: _____
   Please explain any checked items: _____
   B. Blood and Circulatory System
   ☐ Anemia ☐ Leukemia
   ☐ Other; please explain: _____
   Please explain any checked items: _____
   C. Respiratory System
   ☐ Bronchopulmonary Dysplasia
   ☐ Cystic Fibrosis
   ☐ Other; please explain: _____
   Please explain any checked items: _____
   D. Jaundice ☐ Yes ☐ No If yes, was it: ☐ Mild ☐ Severe
   E. Other, please explain:
   _____
6. Was baby colicky? ☐ Yes ☐ No If yes, when did colic go away? _____ months

7. Approximate age baby sat up alone _____ crawled _____ walked _____
8. Were parents or baby's physician concerned about slower than normal motor development? ☐ Yes ☐ No
9. Approximate age baby said first word _____ first phrase _____
10. Were parents or baby's physician concerned about slower than normal language development? ☐ Yes ☐ No
11. Did baby have any significant problems napping/falling asleep? ☐ Yes ☐ No
    If yes, please explain: _____
12. Did baby have any significant problems eating? ☐ Yes ☐ No If yes, please explain: _____
    _____
13. Baby was: (Please check all that apply)

☐ anxious	☐ easy
☐ difficult	☐ happy
☐ cranky	☐ calm
☐ overactive	☐ underactive
☐ difficult to soothe	☐ easily soothed

EARLY CHILDHOOD HISTORY (AGES 2-4)

1. At what age was your child successfully toilet trained? _____ Was training ☐ difficult? ☐ easy?
2. After toilet training, did your child lose control of his/her bladder repeatedly:
   During the day? ☐ Yes ☐ No During the night? ☐ Yes ☐ No
3. After toilet training, did your child lose control of his/her bowels repeatedly:
   During the day? ☐ Yes ☐ No During the night? ☐ Yes ☐ No
4. Was your child: (Please check all that apply)

☐ anxious or extremely shy	☐ overly aggressive
☐ clumsy	☐ too energetic/restless
☐ hard to discipline	☐ unable to understand language
☐ inarticulate	☐ uncoordinated
☐ inattentive	☐ unhappy
☐ noncompliant	☐ destructive
☐ demanding	☐ dependent

5. Did your child attend preschool? ☐ Yes ☐ No
6. Were there significant problems **at preschool**? ☐ Yes ☐ No
   If yes, what were these problems? (Please check all that apply)

☐ overaggressive	☐ unable to share
☐ too energetic	☐ uncoordinated
☐ shy	☐ withdrawn
☐ slow to learn	☐ difficulty getting along with other kids
☐ significant trouble separating	☐ crying/significant distress
☐ clingy	☐ didn't obey
☐ didn't listen	☐ worried excessively about something happening to parents
☐ temper tantrums	☐ other (specify) _____

7. Were there significant problems **at home** during the preschool years? ☐ Yes ☐ No
   If yes, what were these problems? (Please check all that apply)

☐ overaggressive	☐ unable to share
☐ too energetic	☐ uncoordinated
☐ shy	☐ withdrawn
☐ slow to learn	☐ difficulty getting along with other kids
☐ significant trouble separating	☐ crying/significant distress
☐ clingy	☐ didn't obey
☐ didn't listen	☐ worried excessively about something happening to parents
☐ temper tantrums	☐ other (specify) _____

MEDICAL HISTORY

1. Place a check next to any illness or condition your child has had. When you check an item, also note the approximate age(s) and grade(s) of your child when he / she had the illness or condition.

Illness or condition	Age(s) & Grade(s)
☐ Seizures unrelated to high fevers	_____
☐ Convulsions	_____
☐ Epilepsy	_____
☐ Cerebral Palsy	_____
☐ Meningitis	_____
☐ Encephalitis	_____
☐ Tumor	_____
☐ Leukemia	_____
☐ High fever (above 104 degrees)	_____
☐ Fainting spells	_____
☐ Dizziness	_____
☐ Frequent headaches	_____
☐ Extreme fatigue	_____
☐ Significant head injury	_____
☐ Loss of consciousness	_____
☐ Hearing difficulties	_____
☐ Vision problems	_____
☐ Allergies	_____
Please list:	_____
☐ Hay fever	_____
☐ Asthma	_____
☐ Chronic lung disease	_____
☐ Broken bones	_____
☐ Ear infections	_____
☐ Tube placement in ear(s)	_____
☐ Anemia	_____
☐ Diabetes	_____
☐ Cardiovascular disorder	_____

2. Has your child ever suffered from any serious illness / condition not listed above? ☐ Yes ☐ No
   If yes, list condition(s) and age(s)? _____
   _____
3. Has your child ever had any significant accidents? ☐ Yes ☐ No
   If yes, list nature of accidents and age(s): _____
   _____
   _____
4. Has your child ever been hospitalized? ☐ Yes ☐ No If yes, at what age(s)? _____
   For what reasons? _____
   _____
   _____
5. Has your child ever had any surgeries? ☐ Yes ☐ No
   If yes, list procedure(s) and age(s)? _____
   _____
   _____
6. Did your child ever develop motor tics (sudden, brief, recurrent, meaningless movements), such as:
   - ☐ mouth movements
   - ☐ arm jerks
   - ☐ eye blinking
   - ☐ facial gestures
   - ☐ shoulder shrugs
   - ☐ finger movements
   - ☐ head jerks
   - ☐ imitation of someone else's movements
   - ☐ abdominal tensing
7. If so, at approximately what age(s)? _____ Did they last for over one year? ☐ Yes ☐ No
8. If any still exist, which ones? _____
   _____
9. Do they significantly interfere with social, familial, or academic functioning? ☐ Yes ☐ No
   If so, how? _____
10. Did your child ever develop vocal tics (simple, sudden, meaningless sounds or noises), such as:
    - ☐ barking/grunting
    - ☐ repeating his/her own sounds or words
    - ☐ repeating socially unacceptable/obscene words
    - ☐ repeating someone else's sounds or words
    - ☐ sniffing
    - ☐ snorting
    - ☐ throat clearing

    If so, at approximately what age(s)? _____ Did they last for over one year? ☐ Yes ☐ No
    If any still exist, which ones? _____
    Do they significantly interfere with social, familial, or academic functioning? ☐ Yes ☐ No
    If so, how? _____
11. Please list any medications your child is currently taking (and dosage, if known): _____
    _____
12. Who is your child's pediatrician? _____

ACADEMIC SKILLS

1. Has your child ever had any of the following problems with reading?
   - ☐ reading accuracy
   - ☐ reading comprehension
   - ☐ reading speed
   - ☐ trouble with phonics (the sounds of language)

2. Was your child entered into:
   - ☐ Reading Improvement Program (RIP)? If yes, which grade(s)? _____
   - ☐ Title I Reading Class? If yes, which grade(s)? _____
   - ☐ Resource Room (special education) placement? If yes, which grade(s)? _____
3. Has your child ever had trouble with spelling in the following areas:
   - ☐ writing letters backward
   - ☐ print or write neatly under time pressure
   - ☐ needing a lot of help learning weekly spelling words
   - ☐ sloppy handwriting a possible reason for poor spelling
   - ☐ making a lot of spelling errors when writing sentences or compositions
   - ☐ good performance on weekly spelling tests, but difficulty spelling sentences on his/her own
   - ☐ learning spelling words, but forgetting them a week or so later
4. Has your child ever had trouble with arithmetic in the following areas (if age-appropriate):
   - ☐ learning basic addition facts
   - ☐ learning basic subtraction facts
   - ☐ learning to borrow in subtraction
   - ☐ learning multiplication tables
   - ☐ poor handwriting that interferes with writing numbers neatly in columns
   - ☐ making careless arithmetic errors when left alone to do arithmetic homework
   - ☐ understanding arithmetic concepts
   - ☐ understanding math word problems
   - ☐ learning and using decimals
   - ☐ learning and using fractions
   - ☐ learning and using percentages
   - ☐ algebra
   - ☐ geometry
5. Has your child ever had trouble:
   - ☐ understanding the speech of others
   - ☐ with unclear speech / articulation
   - ☐ with stuttering
   - ☐ expressing ideas using age-appropriate words
   - ☐ with late developmental onset of speech
6. Was your child ever placed in speech or language therapy? ☐ Yes ☐ No
   If so, in what grade(s)? _____
7. Has your child ever had difficulty learning how to:
   - ☐ print or write in cursive neatly
   - ☐ hold a pencil correctly
   - ☐ color neatly
   - ☐ button buttons
   - ☐ use scissors
   - ☐ throw or catch a ball
   - ☐ copy information from the blackboard
   - ☐ walk gracefully
   - ☐ run gracefully
   - ☐ tie own shoes (if over 8 years of age)
   - ☐ hold and use utensils correctly
   - ☐ hop on one foot
   - ☐ ride a two-wheeled bicycle without training wheels
8. Did you or teachers ever consider retaining your child in grade? ☐ Yes ☐ No

9. Was your child ever actually retained in grade? ☐ Yes ☐ No
   If yes, which grade(s)? _____
10. Has your child ever:
   - ☐ had problems listening
   - ☐ become easily distracted
   - ☐ had difficulty following instructions
   - ☐ daydreamed frequently
   - ☐ had trouble concentrating
   - ☐ made careless mistakes in schoolwork or other activities
   - ☐ had difficulty organizing tasks and activities
   - ☐ often lost things necessary for tasks or activities (e.g. school assignments, pencils, books, tools, etc.)
   - ☐ become fidgety, squirmy, restless
   - ☐ had trouble remaining seated in class
   - ☐ become excessively talkative
   - ☐ often run around or climbed excessively in inappropriate situations
   - ☐ had difficulty playing or occupying self quietly
   - ☐ remained constantly "on the go"
   - ☐ behaved in an excessively impulsive fashion
   - ☐ had trouble waiting turn in groups
   - ☐ often interrupted or intruded on others
   - ☐ often blurted out answers before questions were completed
11. Has anyone ever used the word "hyperactive" to describe your child (teacher, family member, etc.)? ☐ Yes ☐ No
    If yes, who: _____
12. Has your child ever been placed on any medicine for attentional/hyperactive disturbance? ☐ Yes ☐ No
    If yes, which medicine(s)? _____
    At what age? _____ For how long? _____
    Was it effective? ☐ Yes ☐ No ☐ Unsure

SOCIAL / EMOTIONAL DEVELOPMENT

1. Has your child ever have more than mild difficulty:
   - ☐ showing interest in social games
   - ☐ liking "peek-a-boo" and "pat-a-cake" (ages 1-3)
   - ☐ playing cooperatively with other children (ages 3 and over)
   - ☐ making/maintaining eye contact with people outside immediate family
   - ☐ learning how to share and take turns
   - ☐ being touched, held, or cuddled
   - ☐ tolerating the way things smell, feel, taste, or sound
   - ☐ adapting to changes in routine
   - ☐ repeating words or phrases over and over
   - ☐ speaking with normal vocal tone and/or inflection
   - ☐ invading the personal space of others (e.g., standing too close to others)
   - ☐ changing topics during social conversation
   - ☐ making and keeping friends

2. Has your child ever:

- ☐ feared separation from home or parents
- ☐ feared harm would befall to parents
- ☐ feared going to school
- ☐ had excessive fear of being alone
- ☐ felt reluctant to go to sleep at night
- ☐ felt reluctant to stay with a baby-sitter when you went out at night
- ☐ felt afraid to be away from home overnight
- ☐ had repeated nightmares with the theme of separation from parents
- ☐ complained of physical symptoms (e.g. headaches, stomachaches, etc.) when separating from parents
- ☐ worried about peer acceptance
- ☐ worried about school performance
- ☐ appeared very tense, anxious, or nervous
- ☐ developed any compulsive behaviors (e.g., hand washing, ordering or checking things)
- ☐ repeatedly lost his/her temper
- ☐ often argued with adults
- ☐ often defied adult requests or rules
- ☐ deliberately annoyed other people
- ☐ often blamed others for his/her mistakes
- ☐ become easily annoyed by others
- ☐ become easily angry and resentful
- ☐ become easily spiteful or vindictive

- ☐ had excessive fear of weight gain
- ☐ had excessive fear of weight loss
- ☐ refused to maintain a minimally normal weight for his/her age and height
- ☐ dieted excessively
- ☐ evaluated him / herself excessively based on his / her body weight
- ☐ used laxatives, diuretics, or speed
- ☐ self-induced vomiting after meals
- ☐ engaged in binge eating
- ☐ fasted or exercised excessively
- ☐ missed at least three consecutive menstrual periods (in a menstruating female)

- ☐ exhibited a significantly irritable, depressed, or sad mood lasting at least several days
- ☐ exhibited the loss of pleasure in usual activities that he/she enjoyed
- ☐ complained of appetite changes or sudden weight gain or loss
- ☐ had frequent problems with insomnia or hypersomnia (problems falling asleep or oversleeping)
- ☐ seemed noticeably lethargic, fatigued, or listless for at least several days in a row
- ☐ felt worthless or excessively guilty (low self-worth)
- ☐ seemed pre-occupied with thoughts of death or suicide
- ☐ attempted suicide
- ☐ had periods of enormous energy with little need to sleep
- ☐ become excessively involved in pleasurable activities with negative consequences (buying sprees, sexual indiscretion, reckless driving, etc.)

3. Has your child ever:
   - ☐ threatened or intimidated others
   - ☐ initiated physical fights
   - ☐ used a weapon in a fight
   - ☐ acted in a physically cruel manner to animals
   - ☐ acted in a physically cruel manner to people
   - ☐ stolen while confronting a victim
   - ☐ forced someone into sexual activity
   - ☐ set at least one significant fire
   - ☐ deliberately destroyed the property of others
   - ☐ broken into someone's house, building, or car
   - ☐ often lied to obtain something
   - ☐ stolen valuable items without confronting victim (shoplifting, forgery, etc.)
   - ☐ often stayed out at night despite parental prohibition
   - ☐ run away from home overnight more than once
   - ☐ often engaged in truancy from school, beginning before age 13
4. Did any of these behaviors begin before your child was 10 years old? If yes, which one(s)? _____
   _____
5. Was there ever any Juvenile Court involvement? If yes, what were the charges? _____
   _____
6. Has your child ever used:
   - ☐ alcohol?
   - ☐ amphetamines (crystal meth, speed, ice, diet pills, etc.)?
   - ☐ marijuana?
   - ☐ any form of cocaine?
   - ☐ downers, Valium, Xanax, sleeping pills?
   - ☐ LSD, acid, peyote, or mushrooms?
   - ☐ glue, paint, cleaning agents, solvents, or gas (huffing)?
   - ☐ heroin, morphine, codeine, etc.
   - ☐ PCP (hog, rocket fuel, tranq, angel dust, etc.)?
   - ☐ Ecstasy (MDMA, XTC, X, etc.)
   - ☐ ketamine (Special K, Vitamin K, etc.)?
   - ☐ GHB (liquid ecstasy, soap, etc.)?
   - ☐ rohypnol (roofies, etc.)?
7. Has your child ever (while not using drugs or alcohol):
   - ☐ heard voices talking to him/her
   - ☐ had bizarre or very unusual thoughts
   - ☐ experienced visual hallucinations
   - ☐ seemed out of touch with reality
8. Has your child ever complained of:
   - ☐ frequent headaches
   - ☐ frequent backaches
   - ☐ frequent muscle aches, soreness, tension
   - ☐ frequent stomach problems (nausea, diarrhea, bloating, etc.)
   - ☐ vision troubles (double vision, blindness, etc.)
   - ☐ dizziness or light-headedness
   - ☐ shortness of breath
   - ☐ problems with balance or coordination

9. When interacting with peers, does your child:
   - ☐ not compromise easily
   - ☐ get his/her feelings hurt easily
   - ☐ get picked on by other children
   - ☐ have trouble making friends
   - ☐ act like a poor loser at games
   - ☐ act overly shy
   - ☐ want to run things
   - ☐ express fear that peers did not like him/her
10. Has the child experienced any sexual abuse? If yes, please describe? _____
    _____
    _____
11. Has the child experienced any physical abuse or neglect? If yes, please describe? _____
    _____
    _____
12. Has the child suffered any severe trauma? If yes, please describe? _____
    _____
    _____

CURE 4 THE KIDS FOUNDATION

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Patient Name: _____ **Date of Birth:** _____

If you have insurance, Cure 4 the Kids Foundation (C4K) will gladly process your claim. However, we require that your estimated portion is paid when services are rendered.

IF YOU ARE NOT COVERED BY INSURANCE, we will provide an estimate of the cost of your care. This estimate will include anticipated charges based on the recommended treatment plan. If your plan of treatment changes, you may be asked to agree to a new estimate and estimates may vary due to a variety of factors.

If you are a **SELF-PAY** patient or if you have a financial obligation after your insurance has fulfilled its responsibility, you will be expected to pay the balance due. If you cannot pay your balance in full, payment arrangements may be possible. For payment options, including sliding fee scales, you must speak with our Business Office Representative.

For further understanding of our billing process, please feel free to contact a member of the business office staff by appointment.

Please initial each line:

_____ I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to C4K for all pharmaceuticals, tests, procedures, equipment, supplies, physician/nursing services--including major medical benefits, or services provided to me by C4K.

_____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to C4K, my insurance carrier, state, federal accreditation agency, or other medical entity. A copy of this authorization will be sent to my insurance carrier, or other medical entity, if requested. The original authorization will be kept on file by C4K. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within C4K.

_____ I understand that it is my responsibility to notify C4K of any changes in my health care coverage, insurance carrier, change of address, change of employer or any change in legal guardianship of the minor/patient.

_____ I understand that I am financially responsible to C4K for any charges not covered by health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by C4K and/or my health care insurer, if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility and am agreeing to pay for any/all above described medical services received. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service.

_____ I understand that there is a **$25.00** charge for all returned checks.

_____ I understand that there is a **$25.00** charge for all missed or cancelled appointments that are not cancelled within 24 hours of the scheduled appointment time.

** THIS ACKNOWLEDGEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING **

*By signing this document, I also acknowledge that I have been made aware of C4K's **Notice of Privacy Practices**, as is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights as well as **Understanding our Billing Process**. I have read and, if requested, received a copy of the above statement and Privacy Practices and accept the terms. A duplicate or facsimile transmission of this statement is considered the same as original.*

Signature of Insured/Parent/Guardian: _____ **Date Signed:** _____/_____/_____

Print Name of Insured/Parent/Guardian: _____

CURE 4 THE KIDS FOUNDATION

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth:** _____ **SS#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

I hereby authorize Cure the Kids Foundation to (initial all that apply):

_____ Exchange with _____ Release to _____ Obtain from the parties I have indicated below

Person/Organization receiving/communicating the information:

Name: _____ **Address:** _____

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

Phone #: _____ **Fax #:** _____

Description of individually identifiable health information to be released/exchanged/obtained (initial all that apply):

_____ Entire Record _____ Psychotherapy Notes _____ Treatment Plan(s)
_____ Session Dates _____ Psychological Testing _____ Legal Records
_____ Diagnosis _____ Psychological Report _____ School Records
_____ Other _____

The purpose of this release is (initial all that apply):

_____ To facilitate treatment program _____ Psychological Evaluation
_____ Subpoena or other legal process _____ Court-ordered evaluation
_____ Other _____

**** THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THE SIGNATURE BELOW. ****

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for privacy of Individually Identifiable Health Information and/or state laws. I understand that my records may contain information on regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the release or exchange of these records to/from the parties named above.

Signature of Parent/Guardian: _____ **Relationship to Minor:** _____

Print Name: _____ **Date Signed:** _____/_____/_____

Signature of Witness: _____

Print Name: _____ **Date Signed:** _____/_____/_____

REVOKE CONSENT

I wish to revoke this authorization; however, I understand that it will not have any effect on any information that Cure 4 the Kids Foundation released before I revoked my consent.

Signature to Revoke Consent: _____ **Relationship to Minor:** _____

Print Name: _____ **Date Signed:** _____/_____/_____

INFORMED CONSENT FOR PSYCHOLOGICAL/NEUROPSYCHOLOGICAL SERVICES

CLINICAL SERVICES

Dr. Bello provides psychological therapy, psychological testing, and neuropsychological testing. Testing and psychotherapy are two different services.

Psychotherapy is an intervention process that attempts to reduce patient symptoms. It may involve one-on-one sessions, family sessions, or parent sessions. A treatment plan will be discussed and goals of therapy will be set, though these may change over time. At the time of discharge, if required by referring source, a discharge summary will be written describing treatments provided number of sessions attended, progress made, and presence of possible residual problems.

Psychological/ neuropsychological testing will help the patient and family understand the relationship between behavior and nervous system functioning. The information obtained will help define the existing problem(s) and determine treatment options. The testing process involves an interview (as well as possibly interviewing of others) and the completion of psychological tests. The total time of the evaluation may vary, and it will depend upon the reason for referral, presenting concerns by the patient/parent, and questions that the doctor or the test administrator may have. The time for the interview may be between one to two hours in length, and the time for the testing may be between three to six hours. Common features of evaluations typically include the following:

- **Review of Relevant Records** – background information that enables the doctor to have a historical context that benefits the testing situation.

- **Clinical Interview** – the interview with the patient/collateral typically includes (1) his or her background information, such as family history and past/present physical health, (2) mental health concerns, such as symptoms of distress, and (3) educational and employment history.

- **Testing** – tests will assess cognitive ability as well as emotional status; these are either computerized or paper and pencil tests. Most tests are interactive and will be administered by a neuropsychologist or by a qualified and well-trained testing technician under the supervision of the neuropsychologist.

- **Validity Assessment** – assessment of truthfulness based on the patient's presentation during the clinical interview, effort on testing exercises, and response patterns on the administered tests. It is extremely important that best effort is put forth and complete honesty is given at all times during the testing process.

- **Feedback of Results** – review of the testing results and recommendations with the patient and/or parents.

FREEDOM TO WITHDRAW

The patient/parent has the right to end the evaluation at any time. If the patient wishes to do so, they can be provided the names of other qualified professionals that may help in completing the evaluation.

CONFIDENTIALITY

Confidentiality regarding your treatment is extremely important. Both the state of Nevada and the American Psychological Association Ethical Principles for psychologists require that all information disclosed during the evaluation is kept private and protected. Information that is shared will be kept strictly confidential and will not be disclosed without the patient's written consent. Our staff has been counseled and strictly adheres to these guidelines. If you feel that confidentiality has been breached, please discuss this issue expediently with Dr. Bello or a staff member.

No information will be communicated to other individuals or agencies unless authorized in written form by your signature or the signature of a parent or legal guardian, if you are a minor. However, the following are exceptions:

- If a clear emergency exists where there may be a danger to you or others (e.g., potential suicide/homicide);
- If it is necessary to comply with state and legal status (e.g., known or suspected neglect or child abuse);
- If ordered by the court of law to disclose the information;
- When reimbursement from third party payers is sought (e.g., completing insurance claims for filing);
- When a patient initiates a litigation against the therapist;

In treatment of children and adolescents, the parent is the holder of the privilege of confidentiality. However, if Dr. Bello were to reveal the content of all individual therapy sessions with a minor to his/her parents, a therapeutic bond could not be formed and therefore progress in therapy would be limited. Therefore, we request of parent the same confidentiality with minor children that they would hold as adults. Dr. Bello will review with parents the focus of treatment and specific goals set for treatment with parents of minor children. However, the content of the sessions must remain confidential between Dr. Bello and the minor child with the exception of the above-mentioned limits to confidentiality.

RECORD RETENTION POLICY

Per NRS 629.051, Section 7, psychologists are required to maintain records for adult clients over 23 years of age, for five years. Children's records will be maintained until 23 years of age. After that time, records may be destroyed.

My signature or the signature of parent or guardian below indicates that I have read, understand, and accept the preceding statements. I have had an opportunity to ask questions about them. I hereby give my consent for an evaluation and /or treatment of self and/or my child.

Please sign, date, and return this copy.

Patient Name: _____

Signature of Patient: _____ Date Signed: _____/_____/_____

Signature of Parent/Guardian: _____ Relationship to Minor: _____

Print Name: _____ Date Signed: _____/_____/_____

Signature of Witness: _____

Print Name: _____ Date Signed: _____/_____/_____