Wellness
and Developmental Center

New Patient Questionairre

Date

Name | Date of Birth | Age

Street address, City, ST, ZIP Code

Name and cell

Person completing forms | Email

Marital status | Legal guardian-if applicable

Household members

Name	Relationship	Age	Problems	Diagnosis

Emergency contact information

Name and relationship | Phone #

Name of pharmacy | Phone of pharmacy

Referred by | How did you find us?

Reason for today's visit, concerns and what would you like to accomplish during today's visit

Past medical history (ear infections, allergies, asthma, eczema, seizures, etc.)

Psychiatric History

Past surgical history

Hospitalizations

Current Diagnosis

- ☐ Autism Spectrum Disorder
- ☐ ADHD
- ☐ sensory processing disorder
- ☐ Anxiety
- ☐ Asperger's Syndrome
- ☐ ODD
- ☐ depression
- ☐ Other (please specify below)
- ☐ PDD-NOS
- ☐ Bipolar Disorder
- ☐ OCD

Current Physicians and Addresses

Drug, food, environmental Allergies

Current Medications, vitamins, herbs or supplements

Name	Dose	Date started	Comments/observations

Past Medications, vitamins, herbs or supplements

Name	Dose	Date started/stopped	Reason/observations

Past Labs

Test	Date	Results

Family History

Family medical history please include developmental, medical, immune, psychological

Relationship	Age	Medical History

Current Concerns

Review of Systems

Please check any of the following if applicable

Constitutional

☐No problems, ☐fever, ☐fatigue, ☐weakness, ☐loss of appetite, ☐weight gain, ☐weight loss, ☐night sweats, ☐high pain tolerance

Eyes

☐No problems, ☐vision problems, ☐glasses, ☐vison changes, ☐blurred vision, ☐double vision, ☐dark circles under eyes

Ears

☐No problems, ☐frequent ear infections, ☐hearing problems, ☐hearing aids, ☐recent ear infection, ☐ear pain, ☐ear discharge

Nose, throat, mouth

☐No problems, ☐frequent throat infections, ☐frequent sinus infections, ☐thrush, ☐sores in or around mouth, ☐dry cracked lips, ☐post nasal drip, ☐nose bleeds, ☐stuffy nose, ☐runny nose,

☐difficulty swallowing, ☐sore throat, ☐itchy throat, ☐throat clearing, ☐sinus infection, ☐mouth breather, ☐bad breath, ☐snores, ☐seasonal allergies

Respiratory
☐No problems, ☐frequent cough, ☐wheeze, ☐shortness of breath, ☐cyanosis

Cardiovascular
☐No problems, ☐chest pain, ☐palpitations, ☐murmur, ☐arrhythmia

Gastrointestinal
☐No problems, ☐colic, ☐Abdominal pain, ☐reflux, ☐bloating, ☐nausea, ☐vomiting excessive gas, ☐excessive burping, ☐diarrhea, ☐constipation, BM per day_____, BM consistency_____, BM color_____, ☐foul smelling stool, ☐redness around rectum, ☐recurrent diaper rashes, ☐Soiling/encopresis, ☐difficulty toilet training, ☐history of yeast issues

Genitourinary
☐No problems, ☐difficulty/painful urination, ☐unusual odor to urine, ☐bedwetting, ☐recurrent infection

Musculoskeletal
☐No problems, ☐weakness, stiffness, ☐limited ROM, ☐frequent complaints of aches and pains, ☐scoliosis

Neurologic
☐No problems, ☐unusual movements, ☐starring spells, ☐if yes starring spells if you touch or call the child's name will he or she respond, ☐seizures, ☐motor tics, ☐vocal tics, ☐large or small head, ☐tremors, ☐headaches, ☐dizziness

Sleep
☐No problems, ☐nightmares, ☐difficulty falling asleep, ☐difficulty staying asleep, ☐early wakening, ☐movements during sleep ☐Please describe sleep habits

_____

_____

Hematology/Endocrine
☐No problems, ☐cuts heal slowly, ☐bleeds easily, ☐bruises easily, ☐anemia, ☐excessive thirst, ☐heat or cold intolerance, ☐hair loss

Immunological/allergy
☐No problems, ☐immunization up to date, ☐recurrent infections, ☐stays sick for long periods, ☐difficult to treat infections

Skin
☐No problems, ☐eczema, ☐rash, ☐birth marks, ☐psoriasis, ☐dry or cracking skin/nails, ☐yellow or crusty nails, ☐history of cradle cap, ☐dry or flaking scalp, ☐crust behind ears

Psychosocial
☐No problems, ☐drug or alcohol use , ☐mood swings, ☐aggression, ☐self-injury, ☐smoking

Current Eating Habits

Typical day of eating

Picky eater Yes No Food cravings

Please list any foods that your child cannot tolerate

Please list any other pertinent problems

Wellness & Developmental Center

2006 Highway 71, suite 4 Spring Lake Heights, NJ 07762
Phone: 732-919-1335
Email: info@cwdcenter.com

Welcome and thank you for choosing the Wellness & Developmental Center, LLC (hereinafter "The Center"). In order for us to provide you the best care possible in the timeliest way possible, please read carefully and initial your understanding and willingness to abide by the following practice polices. Feel free at any time to ask questions if there is something you do not fully understand. After you have read and initialed the policy and bill of rights, please sign acknowledging the understanding of what you have read and that The Center have provided you with this important information.

Appointments:

_____New Patients: We ask that you be on time for your appointments and please allow ample time for your visit. Please download and complete the New Patient packet and Notice of Privacy Practices. If applicable bring copies of any lab reports, consultations, and or medical records, you may have for. Please bring any prescriptions or supplements your may be taking.

_____ Follow up Patients: Please bring any prescriptions or supplements you may be taking lab reports, consultations or updated medical records.

_____Cancellation policy is as follows: **If you need to reschedule your appointment it must be done by phone. No later than 24 hours for follow ups and 48-72 hours for new patients, before your scheduled appointment time.** We are mindful of your busy schedules and you must keep in mind that if you don't keep your appointment, that spot could have been given to another patient who needed to be seen.

If you do not cancel your appointment in time or you do not show up for your appointment you will be charged a $50 fee.

Appointments/Cancellation Policy

I understand I ***will be charged $50 for visits not cancelled at least 24 hours before my scheduled appointment*** and that ***cancellations are accepted by voicemail.*** I also understand that payment is due at the time of service.

Signature _____ Date _____

Signature _____ Date _____

Credit Card Payments

#_____

Exp. Date_____

CSC#_____

Billing zip code_____

Signature _____ Date _____

_____Follow ups to review blood work, testing, updated treatment plan, and or to discuss documentation that is needed to be completed, that is not during your regularly scheduled appointment will be billed as a follow up appointment.

_____ Patients must be seen once a year to continue at our practice.

Financial Policy:

_____The Center is a direct-pay service practice. Payment in full is due on the date of service. The Center does NOT accept insurance of any kind. The services that you receive at The Center, may or may not be covered under your out-of-network insurance benefits coverage. It is your responsibility to contact your insurance company directly, prior to your appointment, if you choose to submit any out-of-network benefits. Upon request, The Center will provide you with the necessary form and an itemized invoice to submit to your insurance company. Said documents will be provided to you at the conclusion of your visit so that you may submit them to your insurance company if you chose to do so.

_____ Payments can be made by check, cash or credit cards at the time of services rendered. There is a 2.75 % service charge added to all credit card transactions and a 3.5% service charge for all credit card transactions taken over the phone.

_____All balances must be paid at the time of your appointment. This includes billed charges such as those for no shows, late cancellations, or documentation that was requested to be completed.

_____A $25 fee will be charged for all returned checks

Paperwork:

_____ There will be a $50 fee assessed for any paperwork required from The Center outside of visit documentation, including but not limited to letters, and any other documentation requiring any portion of our time to fill out.

Communication:

_____ We are available to our patients by email and telephone for basic inquiries requiring short responses. Our policy is to return phone or email messages within 48 hours. Messages received between Friday 2pm and Monday 11am will be returned on Monday/Tuesday during the day. **Phone calls NOT initiated by the staff requiring more than 5-10 minutes, will be billed as a follow up appointment.**

Rights:

_____The Center is a multi-disciplinary practice that offers a variety of services for its patients and families. However, if you choose a provider that is outside of The Center's practice, and you give The Center authorization, The Center will work with and communicate with the provider of your choice, in order to treat and to service you.

_____I have assisted The Center in developing my treatment and service plan and as such, I am in agreement with such plan. All individuals that I desired to include in the planning process were invited to participate. I had the ability to choose the services in my Plan. I had the ability to choose the providers of my services based upon the available providers. I am aware of my rights and responsibilities as a participant in this service plan. The Center may share my service plan with all providers in order to implement my treatment. Additionally, I authorize all service providers at The Center to collaborate in order to appropriately service and treat me.

The Center may not share my service plan with :(name listed - only if applicable).

_____

_____

_____

Authorization to be contacted via voicemail, email or text mgs:

_____I authorize The Center, to contact me through voicemail, email or text message. I understand that in doing so, my protected health information may be viewed by individuals I did not intend. I understand that I may revoke this request, in writing, at any time.

Notice of Privacy Practice Acknowledgment:

_____I understand that, under the Health and Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received and read the Notice of Privacy Practices. I understand that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Authorization to Disclose Protected Health Information:

_____I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" under HIPPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
Limitations of Discloser: Please describe below limitations you would like on the disclosure of your Protected Health Information and/or Financial Information

_____

_____

_____

_____

I understand that I may revoke this permission, in writing, at any time. Revoking permission, However, does not affect previous disclosures that were made with my consent.

_____I further understand that The Center is in possession of my personal information. This personal information may include (but is not limited to) my name, my address, my contact information, my emergency contact designee / information, as well as other personal and private information. The Center is also in possession of protected information, known under the law as "Protected Health Information (PHI)." Said information is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

By and through my signature below, I am in agreement with the above provisions and the possible release of the aforementioned information, including PHI, in a manner compliant with HIPAA and other applicable laws.

By completing and signing this form, I, or my legal representative, agree to allow The Center (and its subsidiaries, affiliates, employees, agents and subcontractors) to share my personal information, including PHI, in a manner compliant with the law.

"I have fully read, initialed, understand and agree with the above stated policy. The staff at The Center have verbally explained these policies to me and have answered any questions or concerns that I have. By signing I understand and agree to the policies at The Center."

Patient or Legal Guardian (print name & relationship)

_____

Patient's
Name_____

Signature_____Date_____

Informed Consent for with Treatment The Center, LLC

I, _____, (Patient/Guardian) do voluntary consent to initiate Evaluative / Diagnostic / Therapeutic procedures and Medical Treatment, to clarify issues pertinent to the health, development or adjustment of the patient by the provider/providers at The Center, as is necessary.

I am aware of and understand that the practice of healthcare is not an exact science, and I acknowledge that no guarantees have been made to me as to treatment, evaluation, and/or outcome.
I am aware that I am an active participant in this endeavor, and that I share the responsibility for treatment by providing all accurate information about my history and current health/behavioral status.

My signature below indicates my informed consent. I also understand that I have the right to revoke this consent in writing and terminate services with provider/providers at The Center at any time.

Patient or Legal Guardian (print name & relationship)

_____

Patient's
Name_____

Signature_____Date_____

PATIENT BILL OF RIGHTS

Please read the following carefully and feel free at any time to ask questions if there is something you do not fully understand. After you have read this list of rights, please sign below acknowledging that the Center, LLC have provided you with this important information

It is our **LEGAL DUTY** and **OBLIGATION** to-

-To treat you with consideration and respect in a safe setting, free from all forms of abuse and harassment. Your privacy will be protected.
-To keep all communications and records about your care confidential. In general, you have the right to see all the information in your health records.
-To provide clearly written and spoken information in words you can understand.
-To provide all the information you need to make an informed decision about your care including information about your options, risks and benefits, possible outcomes, possible side effects, who is providing your care and all possible costs.
-To respect your decision to refuse care. To allow you to leave the office even if the physician advises against it.
-To provide you with the freedom of restraints and seclusion of any form that is not medically necessary.
-To provide you with all available information about possible research participation and obtain your informed consent.
-To give you the opportunity to examine and receive an explanation of your bill regardless of source of payment.
- To allow you to express a concern or complaint and receive a prompt response.

You also have the right to file a formal grievance if you are not satisfied with the resolution of your complaint.

I have read and fully understand this Patient Bill of Rights.

Patient or Legal Guardian (print name & relationship)

_____

Patient's Name_____

Signature_____Date_____