Welcome to Attention-MD NJ!

We give our full attention to children with Attention-Deficit-Hyperactivity Disorder (ADHD) and their families; and address the challenges that go along with it. Our evaluation looks at the whole person and we want to begin to get to know you before you arrive for your first visit!

Please fill out the forms that follow completely and feel free to give as much information as needed. Having this information before your appointment helps us use the time at your visit to better address your concerns.

We combine the information in this packet and the information you provide during your appointment, with our FDA cleared state-of-the-art objective testing to help arrive at a more accurate diagnosis.

Whether your child is ultimately diagnosed with ADHD and/or some related condition, we provide support and recommendations to help you address your concerns. Again, we care about the whole child, not just the diagnosis.

If ADHD treatment is needed, we will explain our recommendations and provide the same careful attention to treatment that we do when making a diagnosis. When medication is recommended, we will work with you to find the right solution. You do not want your child to struggle with medication side effects, and at Attention-MD we don't want that either! Response to medication varies significantly from one person to another and our solution helps find the optimal dose of the right medication for your child.

Medication is usually an important part of treatment and often the first step. But Attention-MD is about more than medicine. We are growing our resources to help with ADHD challenges that medication alone may not improve.

Finally, Attention-MD provides careful follow-up to ensure that your child is making progress in reaching their goals. We will discuss a follow-up plan with you during your first visit.

Thank you for choosing Attention-MD NJ. We are committed to taking you and your family "from frustration to focus".

Patient Information Sheet

First:____________________________ Middle: __________ Last Name: _______________________
Nickname: (if applicable) ______________________ Date of Birth: _________________
Gender/Pronouns:________________
Mailing Address____
City:_________________________________ State: _________ Zip Code: _________________ Patient
Parent Email Address: ____
Patient (If over 18 years old) email____
Employer/School:____
Parent Cell Phone: ___________________ Home Phone: ________________

- o I would like to receive Attention-MD NJ newsletters, updates, and health information. How did you hear about Attention-MD NJ? Friend/Relative Doctor Referral: __________________
  Facebook Internet Search/Google Internet Ad

Parent/Spouse/Emergency Contact Information
Name of Parent/Spouse/Legal Guardian: __________________________ Cell #: __________________
Relationship to patient: ____________________________
Is Mailing Address same as patient address? o Yes o No If no, please provide address below: Mailing Address: ______________________________ City: __________________ State: ____ Zip: ________Email: ____

Is the above listed parent/guardian responsible for patient account? o Yes o No If no, please list below:
Responsible party: __________________________ Date of Birth: __________
Mailing Address ______________________________City: __________________ State: ____ Zip: ________

Insurance Information (This is only for reference—we do not submit claims to insurance carriers.)
Insurance Carrier: ______________________ ID #: _____________________ Group #: ______________ Policy Holder's Name _____________________
Policy Holder's Date of Birth: ____________Relationship to patient ____________________
Primary Care Physician Name ____________________________ Phone ______________Address ___________________________ City ________________ State ____ Zip __________

Name of Referring Medical Professional Name ____________________________ Phone _______________ Address _______________________ City ___________________ State ______ Zip________

Preferred Pharmacy Name _______________Phone____________ Address ____________________________City ___________________ State ______ Zip _______
__________________________________ Patient (if over 18) or Guarantor Signature

________________________ Date

PATIENT HISTORY

- Name of person completing this form: Relationship to patient: ______________________
  - What are your main concerns regarding the patient?

  i.e. inattention, distractibility, hyperactivity, impulsivity, academic problems, oppositional behaviors, etc.

____

____

____

____

Help Us Get to Know You

Please have the PATIENT complete this questionnaire. We use this as a handwriting sample.

What do you do well?

What do you enjoy doing most?

Do you find it hard to sit still or do you feel restless during class sessions or in small groups?

Does caffeine affect your sleep?

Do you feel that you finish other people's statements, interrupt, or are impulsive when having to wait to offer comments or ask questions in a classroom/group environment?

Do you find it hard to stay focused when listening to lectures in a classroom setting or meeting?

Do you re-read paragraphs or pages because you didn't get them the first time?

Do your friends and family think you talk too much?

Are you always looking for your phone or keys, or frequently misplace things?

Is procrastination a problem for you?

Do you get frustrated and overwhelmed with schoolwork and job responsibilities?

Are you frequently late or have time management problems?

Are you a worrier?

Do you feel unhappy a lot?

Do you have trouble making or keeping friends?

REVIEW OF SYSTEMS:

Constitutional

Yes No Decreased Appetite
Yes No Decreased Appetite at Lunch
Yes No Excessively Sleepy
Yes No Fatigue
Yes No Problems Falling/Staying Asleep
Yes No Tired
Yes No Weight Gain
Yes No Weight Loss

Eyes

Yes No Frequent Blinking/Squinting
Yes No Itching/Rubbing Eyes
Yes No Vision Problems

Ears/Nose/Throat

Yes No Hearing Loss
Yes No Large Tonsils
Yes No Snoring

Respiratory

Yes No Cough at Night/Wakes Patient
Yes No Frequent Cough
Yes No Shortness of Breath
Yes No Tightness in Chest
Yes No Trouble Breathing

Heart/Vascular

Yes No Chest Pain
Yes No Heart Racing/Fast Heart Rate
Yes No High Blood Pressure
Yes No Palpitations

Gastrointestinal

Yes No Blood in Stool
Yes No Constipation
Yes No Diarrhea
Yes No Frequent Abdominal Pain
Yes No GERD/Reflux/Frequent Heartburn
Yes No Stool Leakage/Accidents
Yes No Vomiting

Musculoskeletal

Yes No Clumsy
Yes No Joint Pain
Yes No Limp or Gait Disturbance

Psychiatric

Yes No Aggression
Yes No Anxious, Worries
Yes No Apathetic/Lazy
Yes No Attempts at Self Harm, Suicide
Yes No Cutting Behavior
Yes No Depressed, Sad
Yes No Flat Effect/Zombie-like

Psychiatric

Yes No Frequent Anger
Yes No Hypersexual Behavior
Yes No Irritable, Touchy
Yes No Low Self Esteem
Yes No Mood Issues Related to Menstruation
Yes No Not Sleeping for over 24 Hours
Yes No Obsessive-Compulsive Behaviors
Yes No Overly Confident or Grandiose
Yes No Paranoid, hears/sees things others don't
Yes No Racing Thoughts
Yes No Rigid, Inflexible
Yes No Sensory Issues- Hates Tags, Loud Noises, Problems with Food Textures
Yes No Special Abilities
Yes No Thoughts of Self Harm, Suicide

Skin/Hair/Nails

Yes No Acne
Yes No Eczema
Yes No Hair Loss
Yes No Sores or Rashes
Yes No Twirls or Pull Hair/Picks at Skin, Nails

Neurological

Yes No Blank Staring Spells
Yes No Frequent Headaches
Yes No Motor Tics – Blinking, Jerking
Yes No Seizures
Yes No Tremor
Yes No Verbal Tics – Sniffing, Throat Clearing, Vocalizing
Yes No Weakness

Endocrine

Yes No Diabetes
Yes No Frequent Urination/Drinks Excessive Fluids
Yes No Problems with Growth/Short Stature
Yes No Thyroid Problems

Heme/Lymph

Yes No Anemia
Yes No Easily Bruised

Allergic/Immunologic

Yes No Allergies
Yes No Asthma
Yes No Food Allergy

Genito/Urinary

Yes No Bed Wetting
Yes No Frequent Urinating
Yes No Irregular, Heavy Period
Yes No Significant Menstrual Pain
Yes No Urine Accident/Incontinence

ALLERGIES: Does the child have any drug allergies? ☐Yes ☐No
If so, please name and describe the reaction: ______________________ The reaction is ☐ Mild ☐ Moderate ☐ Severe

Does the child have any food allergies? ☐Yes ☐No
If so, please name and describe the reaction: __________________________ The reaction is ☐ Mild ☐ Moderate ☐ Severe

CURRENT ADHD MEDICATIONS: ADHD Medication Name: ______________________________Dose: _____mg #tabs/caps _________ time taken ____:_____ am pm

How effective is this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective I take this medication: ☐ Almost if not every day ☐ School/work days ☐Less than 5 days a week This medication lasts: ☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours
The duration of the action is: ☐ adequate ☐ not adequate

ADHD Medication Name: ______________________________
Dose: _____mg #tabs/caps _________ time taken ____:_____ am pm

How effective is this medication? ☐ not effective ☐somewhat effective ☐ effective ☐ very effective I take this medication: ☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week This medication lasts: ☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours
The duration of the action is: ☐ adequate ☐ not adequate

CURRENT OCD/ANXIETY/MOOD MEDICATIONS: Medication Name: __________________________
Dose: _____mg #tabs/caps _________ time taken ____:_____ am pm
How effective is this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective I take this medication: ☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week Side Effects (if any):
____

OTHER CURRENT MEDICATIONS: ____

PAST ADHD MEDICATIONS IN LAST 2 YEARS:

Medication Name: ___________________________ Dose: _____mg _____
Side Effects (if any): __________________________________ How effective was this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective

Medication Name: ______________________ Dose: _____mg ____Side Effects (if any):_________________________________ How effective was this medication? ☐not effective ☐ somewhat effective ☐ effective ☐very effective

FAMILY HISTORY: Please indicate with and X if any of your immediate family members have experienced any of the following conditions. Initial if none: ___________

	Mother	Father	Sibling 1	Sibling 2	Grandparent	Aunt/Uncle
ADHD						
Learning Disorder						
Anxiety						
Panic Disorder						
OCD						
Mood Disorder						
Bipolar Disorder						
Depression						
Schizophrenia						
Tics/Tourette's						
Headache/Migranes						
Autism/Asperger's						
Seizure Disorder						
Addiction/Substance Abuse						
Heart Disease Under Age 40						
High Blood Pressure						
Stroke						
Diabetes						
Cancer						
Asthma						

	Age	***Career/Grade***	***Employer/School***
Parent 1			
Parent 2			
Sibling 1 M/F/U			
Sibling 2 M/F/U			
Sibling 3 M/F/U			

MEDICAL HISTORY: Newborn History

- Were there any pregnancy complications? Yes No ☐ Preterm Labor ☐ Meds During Pregnancy ☐ Drug/Alcohol use During Pregnancy ☐ Other Exposure During Pregnancy ☐ Infection During Pregnancy ☐ Hypertension ☐ Diabetes

  Fertility Assistance Yes/No

- Length of pregnancy? Term Premature Overdue Induced # Weeks: ____________
- Birth Hospital __________________ Birth Weight _________
- Type of delivery: ☐ C-Section ☐ Vaginal ☐ Vacuum Assisted ☐ Forceps Assisted ☐ Meconium
  - Were there any delivery complications? ☐ Yes ☐ No ☐ Difficult Delivery

  ☐ Nuchal Cord ☐ Hemorrhage

- Were there any problems after delivery? ☐ Yes ☐ No ☐ Jaundice ☐ Breathing Problems ☐

  Bleeding in Brain ☐ Bowel Problems ☐ Sepsis/Infection ***Infant History***

  Temperament ☐ Happy ☐ Fussy ☐ Active ☐ Quiet ☐ Colic ☐ Social with People ☐ Anxious around people

  Nutrition ☐ Breast Milk ☐ Regular Formula ☐ Special Formula (Brand) _____________

  Sleep ☐ Good sleeper ☐ Sleep difficulty ☐ Easy to Soothe ☐ Hard to Soothe

  Toddler History
  Please mark all that apply: ☐ Typical interests ☐ Special interests ________ ☐

Quiet ☐ Separation difficulty ☐ Active ☐ Very Active ☐ Explosive tantrums. ☐ Scary Active

Preschool History

☐ Cooperative with Teachers/Children. ☐ Difficult with Teachers/Children ☐ Good with letters/numbers/colors/rhymes ☐ Trouble with letters/numbers/colors/rhymes

Developmental History:

Please mark when the child achieved the following milestones (E = early, A = average, or L = late) when compared to others his/her age (explain if late):

- Speech/Language (single words, sentences) ________
- Fine Motor Skills (stacking blocks, thumb-finger grasp, drawing circle) ________
- Gross Motor Skills (rolling over, standing, walking) ____________
- Toilet Training ___________ Has there been any regression?

____

Sleep History:

- Does the child have a history of sleeping problems? (since infant/toddler years) Yes No

☐ Trouble Falling Asleep ☐ Trouble Staying Asleep ☐ Sleep Walking ☐ Talking in Sleep ☐ Frequent Nightmares ☐ Frequent Night Terrors ☐ Vivid Dreams

- Has the child gone longer than 24 hours without sleep? ☐ Yes ☐ No

If yes, did the child seem tired the next day? ☐ Yes ☐ No
How often has this occurred? _______________
What is the maximum number of days the child has gone without sleep? _______________

- Does the child sleep after school? ☐ No ☐ Yes, Daily ☐ Yes, Occasionally
- How long does he/she sleep? _____________
- Does the child seem tired during the day? ☐ Yes ☐ No
- Does the child fall asleep during the day? ☐ Yes ☐ No

Behavioral/Mental Health History:

- Has the child ever been formally diagnosed with ADHD? If yes, when was he/she diagnosed and by whom? ____
- Do you have documentation of the diagnosis? ☐ Yes ☐ No
- Is he/she currently under a provider's care for ADHD? ☐ Yes ☐ No Why are you changing ADHD providers?

____

- Has the child ever received IQ or Academic Testing? ☐ Yes ☐ No
- Diagnosed with Dyslexia Learning Disability Other Diagnosis _______________________
- Has the child ever participated in counseling, behavioral modification, or therapy? ☐ Yes ☐ No

If so, please explain:
____
____

- Has the child every experienced any of the following conditions or symptoms?
- Depression (sad, irritable, hopeless, tearful, lack of interest, social withdrawal) ☐ Yes ☐ No
- Anxiety (worry, fearful, obsessive thoughts, frequent headaches/stomach aches) ☐ Yes ☐ No

- Behavioral problems (defiance, argumentative, refusals, anger, aggression, school suspensions or detentions) ☐ Yes ☐ No

- Verbal tics (throat clearing, repeating words) ☐ Yes ☐ No
- Motor tics (blinking, face muscle twitching) ☐ Yes ☐ No

General Medical History

Has the child been hospitalized? ☐ Yes ☐ No
If yes, please explain:____

- Has the child ever had a concussion or head injury? ☐ Yes ☐ No If yes, date: _________
- How is the child's vision? ☐ Normal ☐ Vision impairment ☐ Wear corrective lenses or contacts
- How is the child's hearing? ☐ Normal ☐ Some hearing impairment ☐ Uses hearing aid

Please check if the child has ever experienced any of the following symptoms or conditions

☐ *Heart Murmur*	☐ *Cardiac Abnormalities*	☐ *Asthma/Allergies*
☐ *Enuresis (Daytime Accident)*	☐ *Bedwetting*	☐ *Encopresis (soiling w/ stool)*
☐ *Constipation/Diarrhea*	☐ *Thyroid Problems*	☐ *Frequent Ear Infections*
☐ *Seizures*	☐ *Reflux*	☐ *Headaches*
☐ *Diabetes*		

Surgical History

- Tubes ☐ Yes. ☐ No. # Sets _________ 1st Set at what age? ____
- Adenoidectomy ☐ Yes ☐ No
- Tonsillectomy ☐ Yes ☐ No
- Appendectomy ☐ Yes ☐ No
- Other surgery: ____

Social History

Is the patient your biological child? ☐ Yes ☐ No

- If adopted, when was he/she adopted (what age)? ___________
- Has the child ever been the victim of abuse or neglect? ☐ Yes ☐ No
- Parent Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married

- The patient lives with: ☐ Parents ☐ Mom ☐ Dad ☐Mom/Step-dad ☐ Dad/Step-mom ☐ Grandparent ☐ Other relative ☐ Non-relative

If child does not live with both parents, how often does the child see the non-custodial parent?

☐ Frequently/equally ☐ At least weekly ☐ Rarely ☐ No relationship ☐ Every other week ☐ Monthly ☐ Less than monthly

- Does the child have a consistent nighttime routine? ☐ Yes ☐ No ☐ Has a TV in the bedroom ☐ Watches TV/uses electronics before bedtime

  Usual bed time: _____________ Usual wake time: __________

- Does the child have any dietary restrictions? Yes, Explain. _________________________
- ☐ Regular diet ☐ Vegetarian ☐ Other __________________________ • How would you rate the child's physical activity level? ☐ Very active ☐ Active ☐ Somewhat active ☐ Not active/couch potato
- How many caffeinated beverages does the child drink each day? ☐ None ☐ <1 ☐ 1-3perday ☐ 3+perday
- Where does the child attend school? ____________________ Grade ______
- How is the child's academic performance? ☐ Good ☐ Fair ☐ Poor ☐ Failing/Danger of failing
  ☐ Problems with reading ☐ Problems with writing ☐ Problems with math ☐ No Problem ☐ Somewhat of a problem ☐ Moderate Problem ☐ Significant Problem
- How is the child's school behavior? ☐ Good ☐ Disruptive ☐ Oppositional ☐ Meltdowns

- Does the child receive any school-based accommodations? Yes No Needed, but reluctant to use

- ☐ Resource classroom ☐ Individual testing ☐ IEP ☐ Reduced work volume
- ☐ 504 Plan accommodation ☐ Response to intervention ☐ Extended time on testing

- ☐ Informal accommodations ☐ Testing in a quiet environment ☐ Other: _______________

Does the child have any hobbies or activities they enjoy? Yes No

- ☐ Sports/athletics ☐ Hunting/Fishing/Outdoors☐ Music/Band ☐ Video Games ______ Hours per day
- ☐ Drama ☐ Social Media _________ Hours per day ☐ Martial arts ☐ TV/ Media __ Hours per day
- ☐ Art/Creative writing ☐ Electronic/Social Media time is a problem

- Describe the child's after school routine: ☐ Tutoring/Educational Intervention ☐ After school care ☐ Unstructured ☐ Car Rider ☐ Sports/Physical Activity ☐ Rides Bus ☐ Homework is done after school ☐ Homework is delayed until evening

- How is the child's behavior at home?
- ☐ Good behavior ☐ Homework problems☐ Problems with time management
- ☐ Oppositional behavior☐ Problems with task completion ☐ Disrespectful behavior • ☐ Meltdowns ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the child's relationships with family members?

- ☐ No unusual stress ☐ More than usual conflict with siblings ☐ Parent/child conflict
- ☐ Step-parent/child conflict ☐ Conflict with non-custodial parent ☐ Conflict with custodial parent
- ☐ Conflict with other family members ☐ Somewhat of a problem ☐ Moderate problem
- ☐ Significant problem

- How are the child's relationships with peers?

☐ Healthy, identified friends ☐ Limited Friendships ☐ Doesn't identify friends

☐ Some Conflicts ☐ Significant conflict ☐ Problems making/keeping friends ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- Have there been any bullying issues? ☐ No Problems ☐ Child is teased/picked on ☐ Child bullies others ☐ Bullying is ongoing ☐ Bullying is being addressed ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

Have there been any major stressors for the patient in the past year?

- ☐ Family conflict ☐ Absent parent
- ☐ Peer relationships ☐ Serious illness in the family
- ☐ School performance ☐ Death in the family
- ☐ Sibling relationships ☐ Natural disaster
- ☐ Financial stressors ☐ Loss of housing
- ☐ Substance abuse in home ☐ Other____
-
- How many caffeinated beverages do you consume a day? ☐ None ☐ <1perday ☐ 1-3perday ☐ 3+perday

Do you work? ☐ Yes ☐ No ☐ Full Time ☐ Part Time. Type of work: __________________

- Do you use alcohol? ☐ Yes ☐ No ☐ Infrequent ☐ Frequent ☐ Abuse ☐ Concern for addiction

- Do you use chewing tobacco/smoke? ☐ Yes ☐ No

- ☐ Infrequent ☐ Frequent ☐ Concern for addiction
- Do you use marijuana? ☐ Yes ☐ No ☐ Infrequent ☐ Frequent ☐ Abuse ☐ Concern for addiction

- Have you used other drugs? ☐ Yes ☐ No

What is your driving history?

- ☐ No moving traffic violations
- ☐ 2 or less moving traffic violations
- ☐ 3 or more moving traffic violations
- ☐ License suspended/revoked

☐ No accidents
☐ 2 or less accidents
☐ 3 or more accidents

- Do you have any legal issues?

- ☐ Minor w/possession of alcohol
- ☐ Vandalism
- ☐ Stealing/shoplifting
- ☐ Other charges
- ☐ On probation

☐ Possession of drugs
☐ Truancy
☐ Fighting/Assault
☐ Prior incarceration
☐ Off probation

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: __________ Child's Name: ______________________________ Date of Birth: __________

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

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

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

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

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

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

Revised - 1102

DEDICATED TO THE HEALTH OF ALL CHILDREN™

National Initiative for Children's Healthcare Quality

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued

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: __________

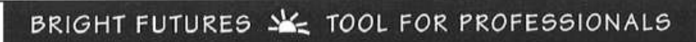
Total number of questions scored 4 or 5 in questions 48–55: __________

Average Performance Score: __________

For Patient's age 14 and older

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
							Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?							
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?							
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?							
10. How often do you misplace or have difficulty finding things at home or at work?							
11. How often are you distracted by activity or noise around you?							
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?							
13. How often do you feel restless or fidgety?							
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?							
15. How often do you find yourself talking too much when you are in social situations?							
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?							
17. How often do you have difficulty waiting your turn in situations when turn taking is required?							
18. How often do you interrupt others when they are busy?							
							Part B



Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people's feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: ____________________ Class Time: ____________ Class Name/Period: ____________

Today's Date: ________ Child's Name: ____________________ Grade Level: ____________________

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: ________.

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. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous 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 in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ
National Institute for Children's Health Quality

HE0351

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: ____________ Class Time: ____________ Class Name/Period: ____________

Today's Date: ________ Child's Name: ____________ Grade Level: ____________

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: ____________________

Mailing address: ____________________

____

Fax number: ____________________

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 19–28: ____________

Total number of questions scored 2 or 3 in questions 29–35: ____________

Total number of questions scored 4 or 5 in questions 36–43: ____________

Average Performance Score: ____________

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11-20/rev0303

NICHQ National Institute for Children's Health Quality

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: ______________________ Date: ______________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	PN
2. I get headaches when I am at school.	O	O	O	SH
3. I don't like to be with people I don't know well.	O	O	O	SC
4. I get scared if I sleep away from home.	O	O	O	SP
5. I worry about other people liking me.	O	O	O	GD
6. When I get frightened, I feel like passing out.	O	O	O	PN
7. I am nervous.	O	O	O	GD
8. I follow my mother or father wherever they go.	O	O	O	SP
9. People tell me that I look nervous.	O	O	O	PN
10. I feel nervous with people I don't know well.	O	O	O	SC
11. I get stomachaches at school.	O	O	O	SH
12. When I get frightened, I feel like I am going crazy.	O	O	O	PN
13. I worry about sleeping alone.	O	O	O	SP
14. I worry about being as good as other kids.	O	O	O	GD
15. When I get frightened, I feel like things are not real.	O	O	O	PN
16. I have nightmares about something bad happening to my parents.	O	O	O	SP
17. I worry about going to school.	O	O	O	SH
18. When I get frightened, my heart beats fast.	O	O	O	PN
19. I get shaky.	O	O	O	PN
20. I have nightmares about something bad happening to me.	O	O	O	SP

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	GD
22. When I get frightened, I sweat a lot.	O	O	O	PN
23. I am a worrier.	O	O	O	GD
24. I get really frightened for no reason at all.	O	O	O	PN
25. I am afraid to be alone in the house.	O	O	O	SP
26. It is hard for me to talk with people I don't know well.	O	O	O	SC
27. When I get frightened, I feel like I am choking.	O	O	O	PN
28. People tell me that I worry too much.	O	O	O	GD
29. I don't like to be away from my family.	O	O	O	SP
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. I worry that something bad might happen to my parents.	O	O	O	SP
32. I feel shy with people I don't know well.	O	O	O	SC
33. I worry about what is going to happen in the future.	O	O	O	GD
34. When I get frightened, I feel like throwing up.	O	O	O	PN
35. I worry about how well I do things.	O	O	O	GD
36. I am scared to go to school.	O	O	O	SH
37. I worry about things that have already happened.	O	O	O	GD
38. When I get frightened, I feel dizzy.	O	O	O	PN
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	SC
41. I am shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. TOTAL =

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. PN =

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. GD =

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. SP =

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. SC =

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. SH =

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: ______________________ Date: ______________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	O	O	O	PN
2. My child gets headaches when he/she am at school.	O	O	O	SH
3. My child doesn't like to be with people he/she does't know well.	O	O	O	SC
4. My child gets scared if he/she sleeps away from home.	O	O	O	SP
5. My child worries about other people liking him/her.	O	O	O	GD
6. When my child gets frightened, he/she fells like passing out.	O	O	O	PN
7. My child is nervous.	O	O	O	GD
8. My child follows me wherever I go.	O	O	O	SP
9. People tell me that my child looks nervous.	O	O	O	PN
10. My child feels nervous with people he/she doesn't know well.	O	O	O	SC
11. My child gets stomachaches at school.	O	O	O	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	PN
13. My child worries about sleeping alone.	O	O	O	SP
14. My child worries about being as good as other kids.	O	O	O	GD
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	PN
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	SP
17. My child worries about going to school.	O	O	O	SH
18. When my child gets frightened, his/her heart beats fast.	O	O	O	PN
19. He/she child gets shaky.	O	O	O	PN
20. My child has nightmares about something bad happening to him/her.	O	O	O	SP

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.	O	O	O	GD
22. When my child gets frightened, he/she sweats a lot.	O	O	O	PN
23. My child is a worrier.	O	O	O	GD
24. My child gets really frightened for no reason at all.	O	O	O	PN
25. My child is afraid to be alone in the house.	O	O	O	SP
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	SC
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	PN
28. People tell me that my child worries too much.	O	O	O	GD
29. My child doesn't like to be away from his/her family.	O	O	O	SP
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. My child worries that something bad might happen to his/her parents.	O	O	O	SP
32. My child feels shy with people he/she doesn't know well.	O	O	O	SC
33. My child worries about what is going to happen in the future.	O	O	O	GD
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	PN
35. My child worries about how well he/she does things.	O	O	O	GD
36. My child is scared to go to school.	O	O	O	SH
37. My child worries about things that have already happened.	O	O	O	GD
38. When my child gets frightened, he/she feels dizzy.	O	O	O	PN
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	O	O	O	SC
41. My child is shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW THIS INFORMATION MAY BE ACCESSED

How we may use and disclose health care information about your child:

For Care or Treatment: Your child's PHI may be used and disclosed to those who are involved in their care for the purpose of providing, coordinating, or managing medical services. ***Example:*** *If another physician referred your child to us, we may contact that physician to discuss your child's care.*

As Required by Law: Under the law, we must make disclosures of your child's PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Complaints: If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Attention-MD NJ,* you may contact your office. Attention-MD NJ at 766 Shrewsbury Avenue Suite 400 Tinton Falls, NJ 07724

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_ ______________________________ Patient (if over 18) or Representative __________ Date

Please check the following if applicable:

__ You may call my cell phone and leave a message on my answering machine if I am not available.

__You may discuss by electronic communication or phone, my child's symptoms (if pediatric patient), diagnosis and treatment with teachers and school representatives.

__I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my child's care or payment for my child's care.

Name:_________________________________Relationship:___________________________________

Name:_______________________________ Relationship:___________________________________

Check all that apply to names above:

- __ All my/my child's medical information
- __ Specific medical information such as test results, prescriptions
- __ Information necessary to help my family member(s) take care of my child.

____________________________________ Patient/Guardian Signature _________ Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize: __________________________________ (practitioner) to release/disclose my child's health information as described below.

Practitioner's Name: ___________________________________
Address: _________________________________ (City) ___________ (State) ________ (Zip) ________
Office Phone: ___________________ Office Fax: ______________________

Please identify the information to be released: ____Please Release ALL Records ____Office Notes ____Testing Results ____Medication List

Please initial below to indicate your understanding:
____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Attention-MD NJ Financial Policy

This financial policy contains important information about payment for our professional services. Payment for professional services may be made by cash, check, or credit/debit card. *It is intended to help us provide your child with the highest level of medical care and help control administrative costs for services provided.* **Attention-MD New Jersey is a fee-for-service provider. Payment for provided services is expected at the time of service.**

At the time of service, the practice will provide an itemized receipt of payment for medical and testing services performed which can be submitted to your insurance company for reimbursement.

Attention-MD NJ will continue to work with insurance companies to help our patient's maximize pharmacy and laboratory benefits, to the best of our ability. We cannot guarantee insurance coverage for all recommended treatments, medications, or laboratory tests.

Our services may or may not be covered by your policy. It is **your** responsibility to contact your carrier to determine if our services are covered under your contract ***prior*** to the date of service Patients 18 years old and above, who are covered under the insurance policy of the parent or guardian, must designate whether responsibility for payment will fall upon the parent/ guardian or themselves.

The fees at Attention-MD New Jersey are as follows:

New Intakes with Doctor: $475: Evaluation includes in-person comprehensive medical and psychosocial history and clinical interview; review of submitted medical information and behavioral symptom forms; and objective neuropsychological testing (QbTest) with interpretation; and treatment recommendations. E/M codes: 99204, 96132. 96138,

<u>Follow-up Visits with Doctor: $135.00</u> Evaluation includes in-person review of interval medical and psychosocial history and clinical interview, with adjustment of treatment as necessary. E/M codes: 99214, 96127

<u>Follow-up Visits with objective neuropsychological testing (QbTest): $250.00</u> Evaluation includes in-person review of interval medical and psychosocial history and clinical interview, with adjustment of treatment as necessary; and QbTest with interpretation. E/M codes: 99214, 96132, 96138, 96127

<u>Telehealth encounter---$90.00</u> Limited to out-of-area college attending patients and patients experiencing a practice-recognized emergency or illness. Evaluation includes a video/audio review of interval medical and psychosocial history and clinical interview with adjustment of treatment as necessary. E/M codes: 99442, 96127.

Non-Medical Services –THESE CANNOT BE SUBMITTED TO INSURANCE

Late Cancellation/No Show Extended Appointment $150	Returned Check $35
No Show Follow-up Appointments $50	Form Completion Fee (Not at Time of Service) $10 per Issue
Accommodation Requests (Extensive) $50	Medical Records Copies ----- $10 Administrative fee plus $1 per page for pages 1-25 /$0.50 per page for pages 26 and over

I have read and understand the financial policy as stated.

______________________________ Guarantor Print Name (Parent/Guardian/Patient)

______________________ Patient (if over 18) or Guarantor Signature ______________ Date

LATE RESCHEDULING/CANCELLATION/NO SHOW POLICY

Our provider's time is reserved for you. We do not double book our patients in order to provide adequate time for each individual appointment. We strive for exceptional care through individual attention. Any appointment rescheduled or cancelled less 24 hours before the appointment day is considered a Late Rescheduling/Cancellation/No Show.

A Late Rescheduling/Cancellation/No Show on a new or extended patient appointment will result in a $150 fee that is not covered by insurance.

A Late Rescheduling/Cancellation/No Show on an established patient appointment will result in a fee of $50 that is not covered by insurance. Repeated Late Rescheduling/Cancellation/No Show appointments will result in unconditional discharge from care at this facility.

I, ___________________________, (patient/parent/legal guardian) acknowledge that I fully understand the Attention-MD NJ Late Rescheduling/Cancellation/No Show policy.

___________________________ Signature Patient/Guarantor ________ Date

Attention-MD NJ Credit/Debit Card Policy

We welcome you to our practice. We look forward to helping your child and you understand and manage the attention, learning and associated conditions that your child faces.
To reduce administrative costs, we will ask you for a credit/debit or health savings card which will securely be held on file and be used to patient balances, charges for evaluations and testing, and non-covered services and fees, which are not paid for in another manner at the time of service. The Card will be used to process professional services, as well as administrative fees under the following circumstances. Any questions regarding our billing procedure can be addressed with our Practice Manager.

1. 1) All services, testing, and office policy fees not otherwise paid within thirty (30) days of fee accrual including but not limited to, missed, or late cancelled appointment fees.
2. 2) Failure to comply with the practices Financial Policy, in total will result in the following: a. No future appointments will be scheduled for the patient.
   b. Your account will be turned over to a collection agency.
   c. We will provide a summary copy of your medical records and ensure prescription for one (1) month supply of appropriate medication. (At the discretion of the medical services provider). We greatly appreciate your understanding and cooperation.

I, ___________________________(parent, legal guardian, patient if 18 or older), acknowledge that I understand the Attention-MD NJ, Credit/Debit card policy.

Card Type: ___________ Name on Card: ____________________________

Card Number: __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __

Expiration Date: ___________. CVV:________

Billing Address: ______________________________________ City:_____

________________________________Guarantor Signature or Patient (if 18 or older) Date__________