DGR Behavioral Health, LLC

2201 Ridgewood Road, Suite 400
Wyomissing, Pennsylvania 19610
Telephone (610) 378-9601
Fax (610) 378-9061

Dear Parent:

In preparation for your child's/adolescent's upcoming evaluation, we ask that you complete the enclosed Client Information Questionnaire. We apologize that the form is quite lengthy. Please realize that collecting this information before the evaluation will help us to utilize the time available to your child's best advantage.

Oftentimes useful clinical impressions can be generated at the very first meeting. Please be aware, however, particularly for children and adolescents, that the evaluation process often entails several meetings before full diagnostic impressions are made.

You may find it helpful to review your child's baby book and other records in order to complete the questionnaire. Also, it is quite helpful to have copies of all past evaluations and any pertinent school records available at the evaluation.

If your child is over age 12, then he or she will be asked to complete a separate Teen Questionnaire which is kept confidential.

The first session will likely involve some time for your child to spend alone with the evaluator as well as some time spent together with you and your child or possibly some time spent separately with you depending on the circumstances and the flow of the evaluation.

Sincerely,

DGR Behavioral Health.

Patient Record Update

Patient Information

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Cell Phone:_____

Guarantor Information - if different from self

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Relationship:_____

Employer Information

Name:_____ Occupation:_____

Add1:_____

City:_____

State:_____ Zip:_____

Insurance Information: Please provide copies of cards to the receptionist

Primary Insurance Information

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

Insurance Information: Please provide copies of cards to the receptionist

Secondary Insurance Information

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Signature: Date:

DGR BEHAVIORAL HEALTH ELECTRONIC COMMUNICATIONS POLICY

E-mail is only for scheduling or for a clinical reason that we can discuss ahead of time.

E-mail is not a substitute for discussions that should take place face-to-face.

E-mails should never be used for emergencies.

Do not e-mail your provider if you expect a quick response, as we only check e-mail occasionally.

We do not follow patients' blogs, follow patients on Twitter, Google them, friend them, or communicate by texting.

Cell phones should be off (or in silent mode) during sessions. Secret recording of sessions is not permitted.

To protect your privacy and respect that of others, please do not have cell phone conversations in the waiting room.

CLIENT INFORMATION QUESTIONNAIRE
ALL INFORMATION CONFIDENTIAL

General Information: Date_____

Child's name_____Age_____Sex_____DOB_____

Address_____State_____Zip_____County_____

Child's Legal Custodian_____Home phone_____

Name of person completing this form_____Relationship to child_____

Referring individual or agency_____Phone_____

Father's name_____Relationship if not biological_____

Mother's name_____Relationship if not biological_____

Biological father's name and address if not living with child_____
_____Frequency of contact_____

Biological mother's name and address if not living with child_____
_____Frequency of contact_____

Name, address, and phone number of person responsible for the bill:

_____

_____

List family members and all others in the home:

Name	Age/Date of Birth	Relationship	Occupation

If parents are separated, how old was child at time of separation?_____
Length of separation_____ If divorced, date_____
List any other siblings (along with age and relationship) not in home:

_____

_____

_____

Please briefly describe your child's current medical, behavioral and emotional problems. Include age at which problems started and any recent stressors:

What seems to help?

Circle any of the following if they have been problems for your child:

Speech or language	Fearful	Slow learner
Coordination	Wets bed	Sad
Prefers to be alone	Bites nails	Stomach troubles
Fights with siblings	Sucks thumb	Angry
Fights with peers	Tantrums	Can't relax
Fights with adults	Nightmares	Lonely
Physically aggressive	Sleep	Feels inferior
Destroys property	Rocking	Suicidal thoughts
Cruel to animals	Head banging	Trouble with friends
Steals	Holds breath	Indecisive
Shy/timid	Poor appetite	Depressed
Reckless behaviors	Stubborn/willful	Nervous
Self injury	Overactive	Bowel problems
Odd habits/mannerisms	Impulsive	Obsessive
Lack of friends		

Developmental History:

Age of mother during pregnancy_____Mother's health ☐good ☐ fair ☐ poor

Any medications during pregnancy (list)_____

Did mother smoke, drink alcohol or use substances during pregnancy?_____
Specify amounts, types, frequency_____

Any illness during or complications of pregnancy (specify)
☐Diabetes ☐ Rh negative ☐Toxemia/preeclampsia ☐
Other_____
Length of pregnancy_____weeks Labor_____hours

Birth weight_____Type of delivery ☐ vaginal ☐ C-section

Any instruments/forceps (specify)_____

Any complications of delivery or birth defects_____

Was mother depressed or down after delivery?_____

Please describe child as an infant:
☐Pleasant ☐ Fussy ☐Calm ☐ Colicky ☐ Irritable ☐ Hard to manage

Any problems with sleep or feeding (describe)_____
_____

Developmental milestones:

To the best of your recollection, please fill in the age at which your child began each of these behaviors:

Showed response to parent_____ Put several words together_____

Rolled over_____ Dressed self_____

Sat alone_____ Toilet trained Bladder_____
Bowel_____

Crawled_____ Dry at night_____

Walked alone_____ Fed self_____

Babbled_____ Rode tricycle_____

Spoke single words_____

Have there been any care givers other than parent prior to kindergarten?

Age Setting Child's reaction/behavior

_____

_____

_____

Medical History

Child's physician_____Date of last exam_____

Please circle any of the following conditions your child has had and list dates or ages

Measles	_____	Whooping cough	_____
German measles	_____	Meningitis	_____
Mumps	_____	Encephalitis	_____
Chicken Pox	_____	Seizures	_____
Rheumatic Fever	_____	Head injury	_____
Broken Bones	_____	Diabetes	_____
Visual problems	_____	Cancer	_____
Hearing problems	_____	Bleeding problems	_____
Paralysis	_____	Frequent nosebleeds	_____
Severe/frequent headaches	_____	Skin conditions	_____
Extreme fatigue	_____	Suicide attempt	_____
Anemia	_____	Bowel problems	_____
Memory problems	_____	Eating problems	_____
Tuberculosis	_____	Loss of consciousness	_____
Fever above 105	_____	Dizziness/fainting	_____

Is your child on a special diet? ☐No ☐Yes Describe_____

Does your child take any medications currently? ☐ No ☐ Yes
Please include any over the counter medications, herbal preparation, or supplements.

Drug	Dose	Frequency	Duration	Reason	Prescribed by

In the past, has your child ever been on any medication for anxiety, depression, behavior problems, etc.? ☐ No ☐ Yes

Drug	Dose	Frequency	Effectiveness	Side Effects	Why discontinued

Does your child have any drug allergies or sensitivities? ☐ No ☐ Yes

Drug	Symptom

Does your child have any other allergies or sensitivities (environmental, food, dye, latex, etc.)?
☐No ☐Yes, describe_____

Caffeine consumption: (soda, tea, iced tea, coffee, etc.) amount_____per day/week

Sexual development:

Has your child started developing sexual characteristics such as pubic hair or breast changes?
☐No ☐Yes

If yes, at what age and what was your child's attitude toward this?_____
_____

If applicable, age at first menstruation_____

Date of last menstrual period_____

Any menstrual irregularities, cramps, other physical discomfort? ☐ No ☐Yes

Child's Psychiatric History:

Has your child ever received any mental health and/or substance abuse treatment?
☐No ☐In-patient ☐Out-patient

Place/Provider	Dates	Reason	Outcome

When was your child last seen by a mental health professional?_____ ☐N/A

Please list name and address of your family doctor and any other physicians or therapists involved in your child's care:_____

_____

_____

_____

Significant events – please check and describe:

Event	Date	Describe
☐Loss of someone close		
☐Loss of pet		
☐Trouble with law		
☐Living placement away from home		
☐Physical abuse or neglect		
☐Incest/sexual abuse		
☐Emotional abuse		
☐Held back in school		
☐Moves		

Child's Education: Grade_____

Name and address of school child presently attends:
_____ Phone_____
_____ Contact person_____

Please check what you feel describes your child in the following areas:

Attendance ☐Rarely absent ☐Sometimes absent ☐Often absent

Ability ☐Above average ☐Average ☐Below average

Relations with classmates
☐Above average ☐Average ☐Below average

Behavior ☐Above average ☐Average ☐Below average

Has your child ever been suspended or expelled? ☐No ☐Yes
If yes, describe_____
_____

Any difficulties with ☐Reading ☐Math ☐Spelling ☐Writing ☐Other

What, if any, special services have been provided for your child in school (speech/language, remedial reading, special classes, counseling, groups, occupational therapy)?

_____
_____
_____
_____
_____
_____

Any school refusal or avoidance? ☐No ☐Yes

Social/Extracurricular activities (list and comment):

_____
_____
_____
_____
_____
_____

Family History:

Is there a family history of any of the following disorders? If so, please check and list family member on adjacent line:

☐Depression_____
☐Manic-Depression (Bipolar)_____
☐Anxiety Disorders_____
☐Suicide Attempt_____
☐Autism_____
☐Attention Deficit/Hyperactivity Disorder_____
☐Tics_____
☐Learning Disorders_____
☐Mental Retardation_____
☐Alcoholism_____
☐Drug Abuse_____

Is there any family history of medical problems, including diabetes, heart disease, cancer, seizures, Alzheimer's, asthma, etc.? ☐ No ☐Yes
Describe_____
_____

Parents' current marital status:
☐Married and living together ☐ Separated ☐Widowed ☐ Mother remarried
☐Single, never married ☐Divorced ☐Living together ☐ Father remarried

How would you describe your marital relationship?
☐No difficulties ☐ Occasional difficulties ☐ Frequent difficulties

Describe significant marital problems and how they are viewed by both spouses:

Mother's view:
_____
_____

Father's view:
_____
_____

Any marital counseling? ☐No ☐ Yes

If yes, when?_____
How many sessions?_____
Reason?_____
Outcome_____

Parents' History:

Biological Mother: Name_____
Birth date_____ Age_____
Occupation_____Place of Employment_____
Education (highest level)_____
Please describe any problems growing up – particularly involving relationships/family:

_____
_____
_____
_____

Biological Father: Name_____
Birth date_____ Age_____
Occupation_____Place of Employment_____
Education (highest level)_____
Please describe any problems growing up – particularly involving relationships/family:

_____
_____
_____
_____

Please complete the following sections as appropriate.

Adoptive/Stepmother: Name_____
Birth date_____ Age_____
Occupation_____Place of Employment_____
Education (highest level)_____
Please describe any problems growing up – particularly involving relationships/family:

_____
_____
_____
_____

Parents' History: (continued)

Adoptive/Stepfather: Name_____
Birth date_____ Age_____
Occupation_____Place of Employment_____
Education (highest level)_____
Please describe any problems growing up – particularly involving relationships/family:

_____
_____
_____
_____

Some managed care companies require we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.
1. With what ethnic/cultural/racial group do you identify?_____
2. What is your religious affiliation?_____
3. What role does your religion/spirituality play in your life? ☐Positive ☐ Negative ☐Neutral
4. Are there any spiritual or cultural issues that you feel need to be taken into account in your treatment? ☐ Yes ☐ No If yes, please identify_____

_____

Please list any additional comments or concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature Date

CONFIDENTIAL
Teen Questionnaire
(To be filled out at office, separate from parent)

Please briefly describe any problems for which you are seeking help:

_____
_____
_____
_____

Please check any of the following if they are problems for you:

☐Nervousness	☐Sexual Problems	☐Concentration
☐Depression	☐Self control	☐Suicidal thoughts
☐Anger	☐Memory	☐Homicidal thoughts
☐Energy	☐Inferiority feelings	☐Finances
☐Sleep	☐Appetite	☐My thoughts
☐Loneliness	☐Friends	☐Bowel troubles
☐Making decisions		

Current caffeine consumption – soda, coffee, tea, iced tea ☐No ☐Yes
Amount_____

Do you drink alcohol? ☐No ☐Yes
Type_____ Amount_____ Last drink_____

Do you use illicit drugs – marijuana, cocaine, etc.? ☐No ☐Yes
Type Amount Last Used
_____
_____
_____

Have you ever experienced unprotected sex, needle sharing, or blood transfusion?
☐No ☐Yes Describe_____

Sexual orientation: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Uncertain

Do you use tobacco in any form? ☐No ☐Yes
Describe_____

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PENNSYLVANIA NOTICE FORM

Notice of Provider's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health care record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would when we consult with another health care provider, such as your family physician or another provider.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Use and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection that PHI. (Please see Section VI for further explanation.) We will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this notice.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we are required by law to report this to the Pennsylvania Department of Public Welfare.

- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and we determine that you are likely to carry out the threat, we must take reasonable

measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

- **Worker's Compensation:** If you file a worker's compensation claim, we will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

- **Coroner's and Funeral Directors:** We may disclose health information about you to a coroner if that information is pertinent to the coroner's duties, such as identifying a decedent or determining the cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

- **Food and Drug Administration (FDA):** We may disclose health information about you to the FDA or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug you are taking or a medical device you are using. Medical devices are rarely used in psychiatry but medications are.

- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – you have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect and obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in your record. We may deny access to your PHI in under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket* – You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- *Right to Be Notified if There is a Breach of Your Unsecured PHI* – You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Provider's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise the policies and procedures, we will post the revision in our waiting rooms, and you may request a copy from our Privacy Officer.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the following person: Privacy Officer, DGR Behavioral Health, LLC, Wyomissing, PA 19610; phone: 610-378-9601.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Psychotherapy Notes

In the course of your care with us, you may receive treatment from a mental health professional (such as a psychiatrist) who keeps separate notes documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session. These notes, known as "psychotherapy notes," are kept apart from the rest of your medical record and typically do not include basic information such as your medication treatment record, counseling session start and stop times, the types and frequencies of treatment you receive, or your test results. Summaries of your diagnosis, condition, treatment plan, symptoms, prognosis, or treatment progress, although they may be contained within those psychotherapy notes, typically are not protected as psychotherapy notes when they appear in other sections of your records.

We will not disclose psychotherapy notes to others unless you have given written authorization to do so, subject to narrow exceptions (e.g. to prevent harm to yourself or others and to report child abuse/neglect.). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health-insurance benefits for your treatment or to enroll in a health plan. If you have any questions, feel free to discuss this subject with your therapist.

Please note that we may deny you access to psychotherapy notes if we determine that disclosure of specific information will constitute a substantial detriment to your treatment; or we will reveal the identify of persons or breach the trust or confidentiality of persons who have provided information upon an agreement to maintain their confidentiality. In very limited circumstances we may also deny you access to other portions of the records. These circumstances include when information was obtained from others under a promise of confidentiality and access would likely reveal the source of the information; and when we determine that access is reasonably likely to endanger the life or physical safety of either you or another person.

VII. Effective Date of Privacy Policy

This notice will go into effect on October 1, 2013.

DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610
Telephone (610) 378-9601
Fax (610) 378-9061

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____

Birth Date: _____

Maiden or other name (if applicable):

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of DGR Behavioral Health, LLC, effective October 1, 2013.

Signature (patient or authorized representative):

_____

Date:

_____

Relationship/authority
(if signed by authorized representative):

_____

Consent to use and disclose your health information

This form is an agreement between you, _____ and DGR Behavioral Health. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority

CANCELLATION POLICY

We consider an appointment to be a commitment and an agreement. When an appointment is scheduled, the time is set-aside for you and no one else. Consequently, unlike other doctors' offices, we do not double or triple book patients. However, in order to do this, we must charge a fee for all appointments not cancelled within 24 hours of the appointment. If your appointment falls on a Monday, you may leave a message with the answering service over the preceding weekend.

Cancelled Appointments:	No charge will be made for any appointment cancelled with at least 24 hours advance notice.
Missed Appointments:	An appointment cancelled on less than a 24-hour notice, or an appointment missed without a notice of cancellation, will be billed a cancellation fee. This fee will not be charged to insurance, and is your responsibility to pay in full.
Exception:	Same-day cancellations because of serious medical/family emergencies or dangerous road conditions (snow and ice) will not be charged, as long as a telephone call is received in the office before the scheduled appointment time.

We will try to give you a reminder call if you have requested one. However, you are responsible for the appointment whether or not you receive that call.

I am aware of the cancellation policy and agree to the terms.

_____ _____

Signature Date

_____

Parent Signature if appropriate