# 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:

## FINANCIAL POLICY

Thank you for choosing our doctors and therapists to meet your needs. The following is a statement of our Financial Policy, which we ask you to read and sign prior to treatment.

Psychiatric and psychological services have already been handled differently by insurance companies than medical/surgical services; therefore we ask you to become as knowledgeable as possible about your particular insurance plan.

YOUR PORTION OF PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AND MASTERCARD.

## MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to________________ __________________________________ for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

## INSURANCE

Your insurance policy is a contract between you and your insurance company. If you have given us all the required information, we can submit the mental health services to the insurance companies with which we participate. We must have current policy, group, ID, and claim numbers. We will make a copy of your insurance card. Please be aware that some services may be "non-covered" services according to your policy. You are still responsible for payment of these services.

Many of us are members of "provider panels" of certain companies. If this is true for your insurance, then part of the payment will come directly to us from the company. You will need to pay a "co-payment" at each visit, the amount of which is determined by *your insurance company* (not be us). You will need to call your insurance carrier to learn what you co-payment will be. You may also need to be in touch with them from time to time in order to make sure that your claims are being paid and that your coverage is still authorized for our services.

If you are covered by an insurance carrier that requires precertification, it is your responsibility to call the company for authorization prior to your first appointment. If you do not have authorization, you will be billed for the services.

We accept the approved amount for some major insurance companies and some HMO and PPO programs, however please have the employer name, claim number, and address of where the claim should be sent. We require written preauthorization from the insurance carrier for all auto insurance and Workers' Compensation cases.

Please note we do not participate in Medical Assistance.

## COMMERCIAL INSURANCE

I hereby authorize the release of information necessary to file a claim with my insurance company and *assign benefits otherwise payable to me to the physician indicated on the claim.*

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature______________________________________ Date_______________________

## MINOR PATIENTS (UNDER 18 YEARS OF AGE)

The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, we will bill our participating insurances, but the parent who brings the child in for services is ultimately the responsibility party.

## FORENSIC EVALUATIONS

Forensic Evaluations are usually not covered by insurance and are paid in full prior to the evaluation unless alternative arrangements are made.

## BILLING

A Billing statement covering your services will be mailed to you each month. We expect payment to be made on a timely basis. A past due account will be turned over to our collection agency if no payment has been made.

I have read, understand, and agree to this Financial Policy.

______________________________________ _______________________

Signature of Patient of Responsible Party Date

## 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______________

Rolled over______________

Sat alone______________

Crawled______________

Walked alone______________

Babbled______________

Spoke single words______________

Put several words together______________

Dressed self______________

Toilet trained Bladder______________
Bowel______________

Dry at night______________

Fed self______________

Rode tricycle______________

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____________________

# Notice of Privacy Practices – Short Version

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

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This pamphlet is a shorter version of the full, legally required NPP which you may request for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If we obtain information that requires us by law to report suspected child abuse.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

**Your rights regarding your health information**

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the office receptionist or Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer: Paul E. Delfin, Ph.D.,
DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610

Phone: 610-378-9601

The effective date of this notice is December 1, 2015.

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 December 31, 2014.

**Signature** (patient or authorized representative):

____________________________________________

**Date:**

____________________________________________

**Relationship/authority**
(if signed by authorized representative):

____________________________________________

# DGR Policies

## 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.

**Please review and keep for your records.**

## FRAGRANCE POLICY

This is a fragrances-free workplace. Thank you for not wearing any of the following during your visit: cologne, after shave lotion, perfume, perfumed hand lotion, fragranced hair products, and/or similar products. Our chemically-sensitive co-workers and clients thank you.

# 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