melmed center

WELCOME!

We appreciate you reviewing the following information in its **entirety & initialing.**

You will be given a copy of your signed Welcome Letter for your records.

Melmed Center has a large team of different care providers including Developmental Pediatricians, Psychiatric Nurse Practitioners, Psychologists, Occupational Therapists, Board Certified Behavior Analysts, Registered Behavior Technicians, and Educational Specialists.

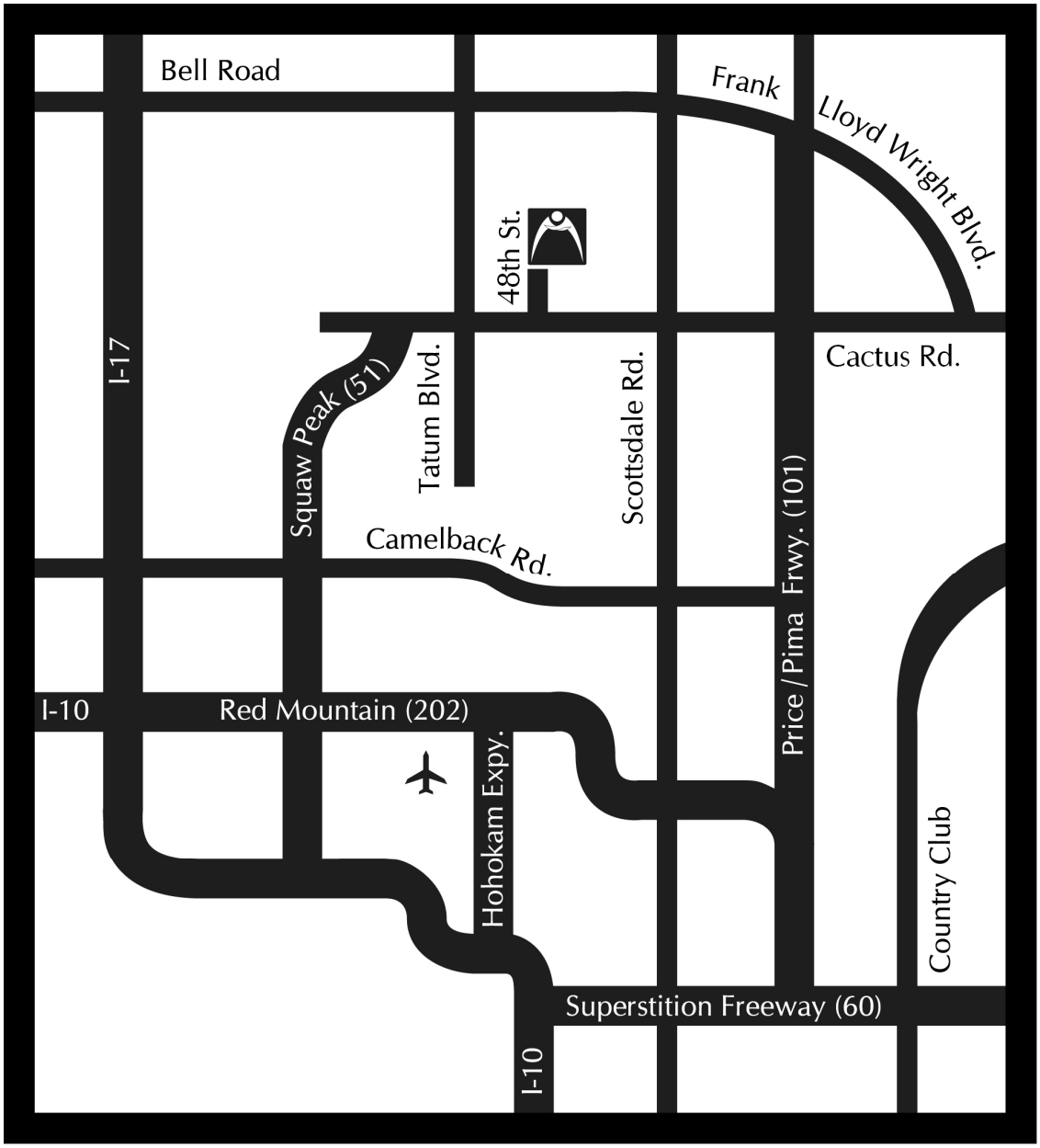
Our goal is to provide our patients with the best possible service. We have listed important items below that will assist us in providing that care. ***Please keep on file for future reference!***

- If you have insurance that our office participates with, please bring your ID card and any necessary forms to ensure proper billing. If your insurance requires a referral, please contact your primary care physician to secure the referral **PRIOR** to each visit. **Failure to do so may result in the cancellation of your appointment or your payment will be out of pocket at time of service.** Since insurance companies have many exclusions of coverage, we suggest that you check with your plan to ensure coverage before your visit. ***Initial:*** _____
- If you **do not** have insurance that our office participates with, we are happy to provide a copy of the attending doctor's superbill for you to submit to your insurance company. ***Initial:*** _____
- Our Psychologists and Therapists are **not** contracted with **any** insurance companies, even if your other medical services at the Melmed Center are covered. Therefore, payment for services is **due at the time of each visit**. ***Initial:*** _____
- **ALL payments are due at the time of ANY service.** Payments can be made by MasterCard, Visa, Discover, check or cash. ***Initial:*** _____
- If your child is being evaluated for learning differences, please bring copies of report cards. Also, please remember to **bring glasses, hearing aids, et cetera** as needed. To obtain the best results, your child should be **well rested** and have had a **healthy meal** prior to the appointment. If your child is on medication for ADHD, please give it to him/her prior to the evaluation. ***Initial:*** _____
- If you have a sensitive situation that will require a private discussion between parent and doctor, **two adults must be present** at the appointment, one to speak with the doctor & one to sit with the child in the waiting room. We do not have daycare and are NOT liable if a child is left unattended. ***Initial:*** _____
- Our providers are NOT responsible to communicate information regarding a visit to a non-attending parent/guardian. Our providers will NOT be calling the non-attending parent/guardian. If it is imperative the non-attending parent/guardian speak to the provider a phone consultation must be made and the fee is NOT covered by insurance. ***Initial:*** _____
- If an adult other than the legal parent or guardian will be bringing the patient to any appointment at Melmed Center, a consent form must be completed **in advance**. ***Initial:*** _____
- Please bring the **completed** Melmed Center packet, **a family picture**, and **copies**, of any previous evaluations that you would like your care provider to have at the initial appointment. As a courtesy, we will duplicate such records at 15 cents per page if you are not able to bring copies. ***Initial:*** _____
- We do **require** confirmation of all new patient appointments, one week prior to the scheduled appointment. Cancellations must be made **48 hours** in advance. You ***will be charged*** if the reserved appointment is not cancelled within 48 hours prior to the scheduled appointment time. The charge will depend on the type of appointment you have scheduled. (If you have further questions about the cancellation fees please contact our office.) ***Signature:*** _____
- You will receive a report **4-6 weeks after** your initial evaluation, it is complimentary. However, there is a charge for additional copies of the report. ***Initial:*** _____
- Our Clinicians are dedicated to returning messages within **24-72 hours**. Please be patient! Do **not** call several times if you have not heard from your clinician immediately. Our Clinicians see patients back-to-back every day and WILL return your call within the allotted time stated above. For emergencies, call 9-1-1. ***Initial:*** _____
- Melmed Center reserves the right to refuse/discharge a patient from treatment and/or services. ***Initial:*** _____
- Audio/video recording is prohibited without written consent from the provider. ***Initial:*** _____
- If the complexity of care is beyond the scope of our practice, the patients will be discharged and referred to an appropriate medical/psychiatric provider. ***Initial:*** _____

Our primary purpose is to provide you with the highest quality developmental pediatric care with courtesy and understanding. Our success can only be measured by your satisfaction with the care you receive. We encourage your feedback on how we may satisfy your needs. By signing here, I understand all policies stated above & will keep for future reference.

Signature: _____ Patient Name: _____ Date: ____/____ (mm yyyy)

We are located at 4848 East Cactus Road, Suite 940 in Scottsdale, AZ on the NE corner of 48th St. and Cactus Road. We are behind Red Lobster and Olive Garden. (see map on back of page)



4848 East Cactus Road, Suite #940 Scottsdale, AZ 85254 (480) 443-0050
www.melmedcenter.com

Support For Life™ at the Melmed Center

REGISTRATION FORM

MUST BE COMPLETED USING A **BLACK** INK PEN

Patient's Legal Name: _____ **M/F:** _____ **Date of Birth:** _____

Marital Status: _____ **Cellular Phone/Other:** _____ **Home Phone:** _____

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

Employer: _____ **Work Phone:** _____

E-Mail: _____ **would you like to receive updates about future programs via E-mail? Circle Yes No**

I authorize Melmed Center to contact me by telephone with medical information pertaining to my care. If I am unavailable, this authorization gives Melmed Center permission to leave this information either on my answering machine or with a member of my household.

Authorized Individuals
The following people are authorized to discuss my personal health information and coordinate with the Melmed Center for evaluation and treatment, including follow up appointments, telephone communication, scheduling appointments and may be contacted in case of an emergency. **(Authorized caregivers are not able to request and transfer records)**

Name_____ Relationship_____Phone Number _____

Name_____ Relationship_____Phone Number _____

*****PLEASE READ***CANCELLED/MISSED APPOINTMENTS*****
A SCHEDULED APPOINTMENT MEANS THAT TIME IS RESERVED ONLY FOR YOU. IF AN APPOINMENT IS MISSED OR CANCELLED FOR ANY REASON, WITH LESS THAN 48 HOURS NOTICE, THE PATIENT WILL BE BILLED ACCORDING TO THE SCHEDULED FEE. THIS FEE IS NOT GENERALLY PAID BY AN INSURANCE COMPANY.
Signature: _____ Date: _____

PRESCRIPTION REFILL POLICY
Our office policy is that all prescription refill requests must be made 7-10 working days in advance of running out of the medication. Refills will only be approved if follow up visits have been kept every 2-3 months. **Prescriptions will be handled only during office hours. Initial**: _____

The Melmed Center has therapy/service animals in our office. **It is your responsibility** to notify our office, **prior to your appointment**, if you have fear of, or allergies to dogs. Melmed Center will not be held liable for any incidents such as licking, nibbling, or physical contact from the dog(s). By signing this document you are aware we do have service/therapy animals in our office. Please contact us if you have any further questions.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____
Signature of Patient

Please turn the page over and complete the other side →

Support For Life™ at the Melmed Center

REGISTRATION FORM

MUST BE COMPLETED USING A **BLACK** INK PEN

FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area. Our office policy is that full private payment or insurance co-payment/co-insurance and/or deductible, as well as, account balances are due at the time of service unless prior arrangements have been made. The adult accompanying the minor patient will be required to pay in accordance with our policies. Please understand that we will only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to insure the claim is paid within 60 days of the date of service. We must emphasize, that as health care providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause. This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 60 days or more and payment plans that are not kept current may be subject to collection and associated fees. Please note claim information processed by the insurance company is mailed to the policy holder. If you are not the policy holder for your insurance, the policy holder (parent, spouse and/or guardian) may receive information from the insurance company pertaining to dates of service and diagnosis. Melmed Center can not be held liable for information being received from the insurance company.

Please note: Insurance cannot be billed without the patient present.

By completing the information below, you assign your insurance benefits to be paid directly to Melmed Center. You also authorize Melmed Center to release any information which may be needed for processing all of claims; certification/case management/quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. Finally, **we require notification of insurance changes at least one week prior** to your appointment to avoid appointment delay and/or private pay expenses.

Insurance Company: _____ Phone: (___)_____ Employer: _____

Group/Policy#: _____ ID#: _____ Employee SS#: _____

Employee/Insured's name: _____ DOB: _____

Insurance Mailing Address: _____

Some medications may require Prior Authorization. Please call your insurance company and find out what provider your PHARMACY BENEFITS are covered through. Please note: This may be located on your insurance card (i.e. Medco, Prescription Solutions, Caremark, and Express Scripts), **if not, we do need this information filled out in its entirety.**

Pharmacy Benefit Provider: _____

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____

Signature of Parent/Legal Guardian

Consent for Purposes of Treatment, Payment, and Health Care Operations

The following information is pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand I have the right to review Melmed Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Melmed Center. Melmed Center reserves the right to change the Notice of Privacy Practices at any time without notice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy or asking for one at the time of my next appointment. The Notice of Privacy Practices is always available at www.melmedcenter.com.

I consent to the use or disclosure of my protected health information by Melmed Center for the purpose of diagnosing or providing treatment to myself, my child, or my family; obtaining payment for my health care bills, or to conduct health care operations of Melmed Center. *"The Privacy Rule protects all individual identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information *'protected health information (PHI).' Individual identifiable health information'* is information, including demographic data, that relates to:

- **The individual's past, present or future physical or mental health or condition,**
- **The provision of health care to the individual, or**
- **The past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g, name, address, birth date, Social Security Number, etc…)."**

I have been informed that a member of Melmed Center, which may include a Developmental Pediatrician, Psychiatric Nurse Practitioner, Clinical Psychologist, Psychiatrist, Educational/Vocational Advocate, Occupational Therapist, Naturopathic Doctor, BCBA, ABA Behavioral Technicians or a medical assistant, will conduct an evaluation on me. An evaluation may consist of clinical interviews, behavioral observations, and review of history, psychological assessment, educational assessment, medical assessment, school visits, home visits, and/or administration of assessment instruments chosen specifically for myself by the clinician. I understand that the clinicians at the Melmed Center work as a multidisciplinary team and therefore one or more clinicians in the practice may see me. I will be informed regarding who my treating clinician will be and I may choose a specific clinician if I so desire. The Melmed Center serves as a training site for several medical and psychological educational programs in Arizona. I may be asked if I consent to have a student, intern, or resident present during the evaluation, intervention, or therapy, and may consent or decline as I wish.

If one or several member(s) of my family participate in the evaluation, therapy, or intervention process, the clinicians have consent to communicate with all family members regarding any issues relevant to the assessment or treatment of any one family member or the family as a whole. I consent to the exchange of verbal and/or written information between the professional team members regarding the care of myself and/or my family. I recognize that unless I have previously expressed my disagreement in writing, Melmed Center has understood that I want them to speak with my parents or guardians about any and all Melmed Center business. This authorization is in effect until such time as I revoke it in writing.

In case of an emergency and in the event that my clinician is not available, I am advised to contact my primary care physician or call 9-1-1 if one's life is in danger. I am further advised to report to the nearest emergency room if emergency assistance is needed.

I understand e-mail communication is a convenience and not appropriate for emergencies or time-sensitive issues. It may take the clinician up to two weeks to receive e-mail, provided they are in the office as regularly scheduled. Melmed Center cannot guarantee the security and privacy of e-mail messages and other staff may read and process the mail, thus highly sensitive or personal information should not be communicated via e-mail. Melmed Center is not responsible for information loss due to technical failures.

I understand that if I choose to sign up for e-mail marketing and/or submit to any online media sights Melmed Center is not responsible for any connection between myself, my family and/or my friends and the center. Media such as Facebook is specifically used for marketing and should not be used as a contact between myself and provider.

Since the clinicians at the Melmed Center can best serve patients when up-to-date medical, educational, and psychological information is available, I consent to have the clinician review all records related to the care, growth and development of the patient. I agree to provide all relevant records specifically including, but not limited to, personal knowledge, intake summaries, treatment plans, progress notes, psychological and developmental history, medical records, physical examinations, psychiatric and psychological evaluations, consultation reports, psychological test results, diagnostic records, educational, social, vocational, speech, occupational and physical therapy records, and legal records. This will serve as notice that Melmed Center reserves the right to disclose protected health information to any local, state, or federal health or law enforcement agency at any time without obtaining consent, if our professional judgment deems it necessary.

Treatment: We may use health information about you to provide medical treatment or services. We may disclose your health information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We may leave messages at the numbers provided by you or with a family member at that number unless we receive in writing a request not to receive such communications.

Payment: We may use and disclose your health information so that the treatment and services you receive at this office may be billed to, and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

Health Care Operations: We may use and disclose your health information in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose your health information in response to a subpoena.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

With the exception of the patient's Primary Care Physician, we will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose your health information, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose your information for the reasons covered by your written *Authorization,* but we can not take back any uses or disclosures already made with your permission.

It is understood that the clinician will provide an evaluation summary to the referral source and/or my primary care physician for coordination of care. By providing the name of my primary care physician below, I consent to the exchange of information between Melmed Center and the following Health Care Provider. Verbal and/or written exchange of information may occur between Melmed Center medical and educational professionals.

Primary Care Physician (Please Print): _____Telephone: _____

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

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a *written* request to Melmed Center Privacy officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe your health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information was generated and is kept by this office.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in *writing* to Melmed Center Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are NOT required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to the Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* to Melmed Center Privacy Officer. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Revoke your Consent: you can revoke your consent at any time by giving us *written* notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

I consent to the evaluation, treatment, or intervention of myself. I certify that this consent has been given freely and voluntarily. By my signature below, I acknowledge that I understand and agree to the above information.

_____ _____

Name of Patient (Please Print) Today's Date

_____

Signature of Patient

melmed center

INFORMED CONSENT FOR TELEHEALTH SERVICES

What is Telehealth?

Telehealth is "the use of telecommunication and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." Telehealth allows Melmed Center providers to diagnose, consult, treat and educate using interactive audio, video or data communication.

I hereby consent to participating in medical treatment, psychotherapy and ABA therapy via telephone or internet with Melmed Center. Telehealth services may be provided by a Developmental Pediatrician, Psychiatric Nurse Practitioner, Clinical Psychologist, Psychiatrist, Counselor, Educational Specialist, Occupational Therapist, BCBA, ABA Behavioral Technician, Nutritionist or a medical assistant.

Potential Risks with Telehealth

A potential risk of telehealth is telehealth services may not be appropriate for all patients and a face-to-face consultation still may be necessary.. Melmed Center utilizes secure, encrypted audio/video transmission software to deliver telehealth. In rare circumstances despite reasonable efforts on the part of Melmed Center, security protocols could fail causing a breach of patient privacy. The transmission of personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. During the COVID situation, alternate means of telehealth services have been deemed acceptable.

Alternative Treatment

Providers shall use their clinical judgement to determine if telehealth services are appropriate. The alternative to telehealth consultation is a face-to-face visit with your provider.

Confidentiality

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

Audio/video recording, streaming or capturing telehealth sessions is prohibited without written consent from the provider. MICA has informed us that due to COVID, a verbal consent is now also acceptable.

We may use health information about you to provide medical treatment or services. We may disclose your health information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. Personnel in our office may share information about you and disclose information to health care personnel who do not work in our office in order to coordinate care, such as phoning in prescriptions to your pharmacy and scheduling lab work.. Family members and other health care providers may be part of your medical care outside this office and may require

information about you that we have. We may leave messages at the numbers provided by you or with a family member unless we receive in writing a request not to receive such communications.

melmed center

INFORMED CONSENT FOR TELEHEALTH SERVICES

Others may also be present during the consultation other than my provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room.

Mandatory Reporting

Any physician, nurse practitioner, psychologist, counselor, educational advocate, BCBA, behavior technician or healthcare worker that "have reason to believe" that a child or adult have been subjected to abuse or neglect, including sexual abuse, are required by law to report this abuse and neglect as mandated reporters.

Medical Records

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Melmed Center Privacy officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Rights

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

Telehealth Recommendations for Patients

To protect your confidentiality and security of your information, we recommend the following:

1. Telehealth session should be held in a private location.
2. Use a private computer or phone.
3. Password protect any technology used to interact with your provider.
4. Hang up and log out of session once it is completed.
5. If providers need to reach you via phone, they might use blocked phone numbers.

In case of an emergency and in the event that my clinician is not available, I am advised to contact my primary care physician or call 9-1-1 if one's life is in danger. I am further advised to report to the nearest emergency room if emergency assistance is needed.

melmed center

INFORMED CONSENT FOR TELEHEALTH SERVICES

Payment for Telehealth Services

Melmed Center will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. Full insurance co-payment/co-insurance and/or deductible, as well as account balances are due at the time of service. Only credit cards will be accepted.

As health care providers, our relationship is with you, our client, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your health insurance benefits.

In the event that insurance does not cover services provided or telehealth it is the individual's responsibility for any unpaid charges as determined by your insurance company. Private pay rates are available when individuals' insurance carriers do not cover telehealth.

Cancellation

A scheduled appointment means that times is reserved for you. If an appointment is missed or cancelled for any reasons, with less than 48 hours' notice, the patient will be billed according to the scheduled fee. This fee is not generally paid by an insurance company.

Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Name of Patient/Client _____ Date _____

Parent/Guardian Name _____ Parent/Guardian/Patient Signature _____

Parent or Guardian Signature _____ Phone Number _____

MELMED CENTER
INFORMED CONSENT, RELEASE OF LIABILITY AND WAIVER DURING COVID-19

1. I _____, understand that I am opting for in-person evaluation and treatment for me or my child at Melmed Center. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact and accordingly, federal and state health agencies recommend social distancing.

2. I recognize that Melmed Center is closely monitoring this situation and has implemented reasonable preventive measures targeted to reduce the spread of COVID-19. Given the nature of the virus, however, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with therapy, in-person, for me or for my child at the Melmed Center.

3. Although we strongly recommend that all employees and patients be vaccinated, we recognize that some individuals have elected not to be vaccinated because of medical or religious considerations.

4. I have been given the option of using teletherapy for services or deferring services at this time. However, I understand all the health potential risks and have chosen to proceed with center-based services.

5. Accordingly, I acknowledge and assume the risk of becoming infected with COVID-19 through this elective therapy session, and I give my express permission for the providers and staff at Melmed Center to proceed with therapy.

6. I understand that possible exposure to COVID-19 before/during/after my child's therapy session may result in any of the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical treatment, intensive-care treatment, or other potential complications that may lead to loss of life. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time.

7. I acknowledge that I am responsible for adhering to Melmed Center's visitation policies and procedures, including practicing social distancing, performing frequent hand hygiene, limiting surfaces that I touch, refraining from touching others during the visit, wearing recommended personal protective equipment ("PPE") such as a facemask or disposable gloves.

8. I am not experiencing, nor is any person in my household experiencing respiratory illness symptoms, including but not limited to: fever, cough, sore throat, or shortness of breath. I will notify the Melmed Center immediately should I, or anyone in my household experience respiratory illness symptoms within 14 days after my visit to Melmed Center.

9. I understand all the health potential risks and have chosen to proceed with in-office services. I acknowledge that I have been offered a copy of this consent form.

10. If I test positive 3 – 5 days after an in-office appointment I will notify the front office.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND FULLY UNDERSTAND THAT BY SIGNING IT I AM GIVING UP CERTAIN LEGAL RIGHTS AND CLAIMS THAT MAY ARISE IN THE FUTURE AND DO SO VOLUNTARILY. I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TREATMENT FOR ME AND FOR CHILD.

_____ _____
Signature of Patient (or Parent or Guardian) Date

_____
Patient's Name (Printed)

Support For Life™
at the Melmed Center

Melmed Center
Adult Intake Questionnaire

Patient's Name:

Please attach picture here.

Support For Life™ at the Melmed Center

Adult Intake Questionnaire

In order to serve you better, please complete all of the following questions. Feel free to add any extra comments in the spaces provided on the front or back cover. Please use a black pen, and bring the finished questionnaire to your appointment.

Date of visit: _____ / _____ /_____
Name: (FIRST) _____ (LAST) _____
Age: _____ Date of Birth: _____/_____/_____ Who referred you? _____
Who is your primary care physician? _____

A. YOUR EXPERIENCE & INSIGHTS

1. What are your chief concerns that led you to seek an evaluation? _____
   _____
   _____
   _____
2. When did you first notice these concerns? _____
   _____
   _____
   _____
3. Did you ever seek treatment for these concerns before? ○ Yes ○ No
   If yes, when and where did you seek treatment? _____
   _____
   _____
   _____
4. What seems to have helped the most? _____
   _____
   _____
   _____

B. CHILDHOOD HISTORY

5. Did anyone ever have concerns about your language skills? ○ Yes ○ No
6. Did anyone ever have concerns about your social skills? ○ Yes ○ No
   If yes, please explain. _____
   _____
   _____
7. Did you ever repeat a grade? ○ Yes ○ No
8. Were you ever in any special classes? ○ Yes ○ No
   If yes, what were they? _____
9. Were you ever expelled or suspended from school, or ever ran away from home? ○ Yes ○ No
   If yes, for what? _____

10. Please provide the following information regarding your education levels:

Education	Name of School	Did you graduate?	Subjects studied and degrees received
High School	_____	Y N	_____
College	_____	Y N	_____
Post College	_____	Y N	_____
Trade, Business, or Correspondence School	_____	Y N	_____

11. Have you ever been arrested or in trouble with the law? ○ Yes ○ No
    If yes, for what? _____

12. Have you had speeding tickets or accidents? ○ Yes ○ No
    If yes, please explain: _____
    _____
    _____

C. PERSONAL & FAMILY MEDICAL HISTORY

Have you or anyone in your biological family (including parents, grandparents, aunts, uncles and cousins) ever had any of the following medical conditions?

PROBLEM	SELF	RELATIVE	Comments
High blood pressure	○	○	_____
High cholesterol	○	○	_____
Heart attack (what age?)	○	○	_____
Heart palpitations	○	○	_____
Structural heart defects	○	○	_____
Sudden death	○	○	_____
Asthma	○	○	_____
Migraines	○	○	_____
Seizures	○	○	_____
Fainting	○	○	_____
Loss of consciousness	○	○	_____
Tics	○	○	_____
Diabetes	○	○	_____
Thyroid disease	○	○	_____
ADHD	○	○	_____
Anxiety	○	○	_____
OCD	○	○	_____
Depression	○	○	_____
Bipolar disorder	○	○	_____
School challenges	○	○	_____
Learning problems	○	○	_____
Glaucoma	○	○	_____
Alcoholism/drug abuse	○	○	_____
Autoimmune disorders	○	○	_____
Liver Disease	○	○	_____

13. Was your birth complicated by any medical problems? ○ Yes ○ No
    If yes, please explain: _____

14. Were you adopted? ○ Yes ○ No

15. Were there any developmental delays? ○ Yes ○ No
    If yes, please explain: _____

16. Do you have any allergies to medications or foods? ○ Yes ○ No
If yes, please explain: _____
_____
_____

17. Please indicate which of the following difficulties apply while sleeping:
○ None ○ Falling asleep ○ Staying asleep
○ Excessive sleeping ○ Sleepwalking ○ Nightmares
○ Waking up tired ○ Excessive snoring ○ Teeth grinding

18. If applicable, please describe other sleep habits: _____
_____
_____

19. How much caffeine do you drink (tea, soda, or energy drinks) in a typical day?
a. 2-4 drinks
b. 5-10 drinks
c. More than 10
d. Never Drink

20. Do you smoke? ○ Yes ○ No
If yes, how many times per day? _____

21. How much alcohol do you drink in a *week*?
e. 2-4 drinks
f. 5-10 drinks
g. More than 10
h. Never Drink

22. Did you ever drink more heavily? ○ Yes ○ No
If yes, please explain: _____

23. Have you ever felt you ought to cut down on your drinking? ○ Yes ○ No

24. Have people annoyed you by mentioning your drinking? ○ Yes ○ No

25. Have you ever felt bad or guilty about your drinking? ○ Yes ○ No

26. Have you ever had a drink in the morning to steady nerves, cure a hangover, as an eye-opener? ○ Yes ○ No

27. Have you now or in the past used any of the following drugs? ○ Yes ○ No
If yes, please note the frequency of use below.

	Past	**Current**	**Frequency**
Marijuana, hash	○	○	_____
Amphetamines, stimulants, cocaine	○	○	_____
Barbiturates, sedatives, sleeping pills	○	○	_____
Tranquilizers	○	○	_____
Heroin, Opiates, Demerol, Morphine	○	○	_____
Psychedelics (LSD, mescaline, peyote)	○	○	_____
Prescription Drugs	○	○	_____
Other (*please specify):*	○	○	_____

28. Have you ever been hospitalized medically? ○ Yes ○ No
If yes, please describe: _____

29. a) Please list all current and past medications that you have taken to help with behavioral or emotional problems, as well as other chronic conditions. *Please list the prescribing doctor.* (We need to be aware of possible medication interactions.)

Age Start - Stop	Medicine	Doctor	Reason	Currently Taking
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○

b) Please list all current and past supplements, remedies, nutriceuticals or vitamin products that you have taken.

Age Start - Stop	Supplement	Doctor	Reason	Currently Taking
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○

30. Have you ever seen a counselor, psychologist, or psychiatrist? ○ Yes ○ No
If yes, who, when and why did you see them? _____
_____
_____

31. Have you ever been hospitalized for a psychological/psychiatric problem? ○ Yes ○ No
If yes, please describe: _____
_____
_____

D. DIET & EXERCISE

32. Do you feel that certain foods affect your focus and/or attention? ○ Yes ○ No

33. Do you have a hard time determining what to eat on a daily basis? ○ Yes ○ No

34. Is your daily intake deficient of protein, vegetable, fruit, grain, and dairy? ○ Yes ○ No

35. Do you have a hard time deciding what is healthy to buy at the grocery store? ○ Yes ○ No

36. How important is physical activity to you?
a. Not Important b. Somewhat Important c. Very Important

37. Do you have difficulty getting enough physical exercise? ○ Yes ○ No
If yes, what is it primarily due to? *(Please circle all that apply)*
a. Lack of motivation b. Inability to find time c. Physical barriers (injuries, expenses, etc.)

38. Do you give up or find yourself frustrated when working towards a fitness goal? ○ Yes ○ No

39. Do you feel exercise affects your mood or feelings? ○ Yes ○ No

40. Do you have any concerns with your weight? ○ Yes ○ No
If yes, please describe: _____
_____
_____

E. WORK & SOCIAL HISTORY

41. Do you have a hard time staying motivated at work? ○ Yes ○ No
42. Are you bored at work? ○ Yes ○ No
43. Do you have interpersonal problems with co-workers, supervisors, or customers? ○ Yes ○ No
44. Do you feel that your profession does not match your strengths? ○ Yes ○ No
45. Do you have trouble honoring commitments with others? ○ Yes ○ No
46. Please describe your past work history. _____
_____
_____
47. Please describe any challenges and/or reasons for leaving previous careers. _____
_____
_____

F. RELATIONSHIPS & FAMILY LIFE

48. Are you currently in an intimate relationship? *Please circle the best description*
Single Married Living together Separated Divorced Widowed
How long? _____
49. Please list the names, ages and relationships of others in your household.

Name	Age	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

State the approximate extent of agreement or disagreement between you and your significant other on the following.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
Handling Family Finances	○	○	○	○	○	○
Matters of Recreation	○	○	○	○	○	○
Demonstrations of Affection	○	○	○	○	○	○
Friends	○	○	○	○	○	○
Philosophy of Life	○	○	○	○	○	○
Ways of dealing with in-laws	○	○	○	○	○	○

50. Do you have trouble in your relationships with others? ○ Yes ○ No
If yes, please explain: _____
_____
_____
51. Do you have trouble empathizing with your significant other? ○ Yes ○ No

52. Do you struggle to find quality time for your family? ○ Yes ○ No
53. Do arguments/tensions arise often in your family life? ○ Yes ○ No
54. Does your disorganization contribute to a chaos-driven home life? ○ Yes ○ No
55. Does it feel that no one is supportive of your challenges within your household? ○ Yes ○ No

G. FINANCES & ORGANIZATION

56. Do you participate in impulsive buying? ○ Yes ○ No
57. Do you overdraft frequently? ○ Yes ○ No
58. Do you feel your impulsivity inhibits you to successfully manage your finances? ○ Yes ○ No
59. Do you feel you need a budget? ○ Yes ○ No
60. Do finances cause increased stress in other areas of your life? ○ Yes ○ No
61. Have you ever bought something to "make you feel better"? ○ Yes ○ No
62. Do you struggle with time management planning? ○ Yes ○ No

H. SPIRITUALITY/MINDFULNESS

Please Note: *This section is optional. It is used simply as a guide to help patients reveal their spirituality/mindfulness.*

Please rate each statement by circling the number that best describes your spirituality/mindfulness.

	Disagree	Strongly Disagree	Agree	Strongly Agree
63. Spirituality is important to me	○	○	○	○
64. I have a strong direction or a higher power that I depend on	○	○	○	○
65. I effectively use positive thinking to empower my goals	○	○	○	○
66. I have a spiritual practice that I use in times of despair	○	○	○	○

Please include any additional comments related to the role of spirituality in your life. _____

_____

_____

_____

I. ADULT ADHD SELF-REPORT SCALE (ASRS-v1.1) SYMPTOM CHECKLIST

Please answer the questions below, rating yourself on each of the criteria. Circle the number that best describes how you have felt and conducted yourself over the past *6 months*.

	How often do you…	Never	Rarely	Sometimes	Often	Very Often
1	Have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2	3	4
2	Have difficulty getting things in order when you have to do a task that requires organization?	0	1	2	3	4
3	Have problems remembering appointments or obligations?	0	1	2	3	4
4	When you do a task that requires a lot of thought, do you avoid or delay getting started?	0	1	2	3	4
5	Fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3	4
6	Feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3	4
7	Make careless mistakes when you have to work on a boring or difficult project?	0	1	2	3	4
8	Have difficulty keeping attention when doing boring, repetitive work?	0	1	2	3	4
9	Have difficulty concentrating on what people say, even when they speak to you directly?	0	1	2	3	4
10	Misplace or have difficulty finding things at home or at work?	0	1	2	3	4
11	Get distracted by activity or noise?	0	1	2	3	4
12	Leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	4
13	Feel restless or fidgety?	0	1	2	3	4
14	Have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	4
15	Find yourself talking too much in social situations?	0	1	2	3	4
16	Find yourself finishing sentences for people you are talking to, before they can finish themselves when in conversation?	0	1	2	3	4
17	Have difficulty waiting your turn in situations when turn taking is required?	0	1	2	3	4
18	Interrupt others when they are busy?	0	1	2	3	4

J. BEHAVIORAL INVENTORY

	Check which best describes your behavior.	Never	Sometimes	Often	Very Often
1	Depressed or irritable nearly every day for at least two weeks	○	○	○	○
2	Diminished interest or pleasure in activities nearly every day during the same 2-week period	○	○	○	○
3	Significant change in appetite and/or weight not due to dieting within the same 1 month period; or not meeting the expected weight gain	○	○	○	○
4	Difficulty sleeping or sleeping too much nearly every day during the same 2-week period	○	○	○	○
5	Restless or slowed down nearly every day during the same 2-week period	○	○	○	○
6	Feel worthless or guilty nearly every day during the same 2-week period	○	○	○	○
7	Decreased ability to think or concentrate; or difficulty making decisions, nearly every day during the same 2-week period (or as observed by others)	○	○	○	○
8	Repeated thought of death or suicide, or a suicide plan or attempt	○	○	○	○
9	The above behaviors interfere with relationships and/or work	○	○	○	○
10	You felt so good or so hyper that other people thought you were not your normal self or you got into trouble?	○	○	○	○
11	You were so irritable that you shouted at people or started fights or arguments?	○	○	○	○
12	You felt much more self-confident than usual?	○	○	○	○
13	You got much less sleep than usual and found you didn't really miss it?	○	○	○	○
14	You were much more talkative or spoke much faster than usual?	○	○	○	○
15	Thoughts raced through your head or you couldn't slow your mind down?	○	○	○	○
16	You were so distracted by things around you that you had trouble concentrating or staying on track?	○	○	○	○
17	You had much more energy than usual or go for days without rest?	○	○	○	○
18	You felt invincible or "on top of the world"?	○	○	○	○
19	You were much more social or outgoing than usual, i.e. (you telephoned friends in the middle of the night)?	○	○	○	○
20	You were much more interested in sex than usual?	○	○	○	○
21	You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○	○	○
22	Spending money got you or your family in trouble?	○	○	○	○
23	Have several of these behaviors ever happened during the same period of time?	○	○	○	○
24	Have the behaviors above contributed to problems?	○	○	○	○
	Check which describes you.	**Never**	**Sometimes**	**Often**	**Very Often**
25	Anxious and worried about a number of issues	○	○	○	○
26	Difficulty controlling worry	○	○	○	○
27	Restless	○	○	○	○
28	Easily tired	○	○	○	○
29	Difficulty concentrating or mind goes blank	○	○	○	○
30	Irritable	○	○	○	○

	Check which describes you.	Never	Sometimes	Often	Very Often
31	Muscle tension	○	○	○	○
32	Sleep disturbance	○	○	○	○
33	I am unusually fearful of becoming embarrassed or humiliated in interactions with other adults.	○	○	○	○
34	I withdraw, or panic when exposed to a feared social situation.	○	○	○	○
35	I try to avoid a feared social situation or am very distress in its presence.	○	○	○	○
36	Do these symptoms interfere with your relationships?	○ Yes	○ No		
37	Do these symptoms interfere with your work?	○ Yes	○ No		
38	Do these symptoms interfere with your home functioning?	○ Yes	○ No		

	Answer each question to the best of your ability	Never	Sometimes	Often	Very Often
39	I do unusual movements for no apparent reason (eye blinking, twitching, lip licking, head jerking, rocking, etc.)	○	○	○	○
40	I make vocal sounds for no apparent reason (coughing, throat clearing, sniffing, grunting, etc.)	○	○	○	○
41	Both of above having a duration of more than one year	○ Yes	○ No		
42	The difficulties in this category are currently present	○ Yes	○ No		
43	I cannot verbally communicate my needs	○	○	○	○
44	I do not respond to questions	○	○	○	○
45	I cannot understand simple instructions	○	○	○	○
46	People say I have unusual language understanding or usage	○	○	○	○
47	I speak using overly correct grammar	○	○	○	○
48	I talk in a strange way (repeat others; use odd words or phrases, etc.)	○	○	○	○
49	I have a peculiar way of relating to others (avoid eye contact, different facial expressions or gestures; don't smile at others, etc.)	○	○	○	○
50	I could be characterized as being unfriendly	○	○	○	○
51	I'm told what I said is impolite even though I think it is polite	○	○	○	○
52	People say, I do not respect the personal space of others	○	○	○	○
53	I am uninterested in making friends at peer level	○	○	○	○
54	I am unaware or take no interest in other people's feelings or interests	○	○	○	○
55	I do not enjoy new experiences or meeting new people	○	○	○	○
56	I do not enjoy social activities	○	○	○	○
57	I am a loner	○	○	○	○
58	I find criticism or praise to be unimportant	○	○	○	○
59	I find close relationships to be unnecessary	○	○	○	○
60	I tend to monopolize when talking with others	○	○	○	○
61	I have trouble starting or ending conversions	○	○	○	○
62	I am unable to keep a conversation going	○	○	○	○
63	When talking to someone, I focus on my own thoughts rather than on what my listener might be thinking	○	○	○	○
64	I cannot tell if someone listening to me is getting bored	○	○	○	○

		Never	Sometimes	Often	Very Often
65	I have trouble understanding jokes, sarcasm, metaphors, etc.	○	○	○	○
66	I am unable to "read between the lines" when someone is talking to me	○	○	○	○
67	I interpret words literally	○	○	○	○
68	I have strange fascination for parts of objects	○	○	○	○
69	I engage in self soothing behaviors others find unusual (spinning, rocking)	○	○	○	○
70	I have unusual preoccupations that I cannot stop thinking about	○	○	○	○
71	My special hobbies occupy all of my time	○	○	○	○
72	I collect information about categories of things	○	○	○	○
73	I display an obsessive interest in a narrow subject	○	○	○	○
74	I impose my interests on others	○	○	○	○
75	I make strange repetitive movements (flapping arms, etc.)	○	○	○	○
76	I perform a behavior repeatedly or "obsessively"	○	○	○	○
77	I have sensitivity to noise, light, and touch (difficulty wearing certain materials)	○	○	○	○

K. PERSONALITY

		Never	Sometimes	Often	Very Often
1	I have difficulty making decisions	○	○	○	○
2	I like to get advice before deciding	○	○	○	○
3	Disagreeing with others is hard for me	○	○	○	○
4	I am dependent on others	○	○	○	○
5	I worry that people I care about will leave me	○	○	○	○
6	I have many short term relationships that are intense and stormy	○	○	○	○
7	I feel empty or hollow inside	○	○	○	○
8	My feelings are intense and unpredictable	○	○	○	○
9	I am sensitive to rejection	○	○	○	○
10	I worry about embarrassing myself	○	○	○	○
11	I feel deeply hurt when criticized	○	○	○	○
12	I feel inferior to others	○	○	○	○
13	I am superior to others in many ways	○	○	○	○
14	I feel hurt when I do not get deserved recognition	○	○	○	○
15	I find others admire me	○	○	○	○
16	I have a right to special consideration	○	○	○	○
17	I often believe extraneous events have direct personal meaning	○	○	○	○
18	I make things happen just by thinking about them	○	○	○	○
19	I hear sounds others do not	○	○	○	○
20	My eyes play tricks on me	○	○	○	○
21	I am often suspicious of people and their motives	○	○	○	○

Have we covered everything? Can you think of any other problems that might be related to why you have scheduled an appointment with us?

_____

_____

_____

_____

_____

Thank you!

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