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.

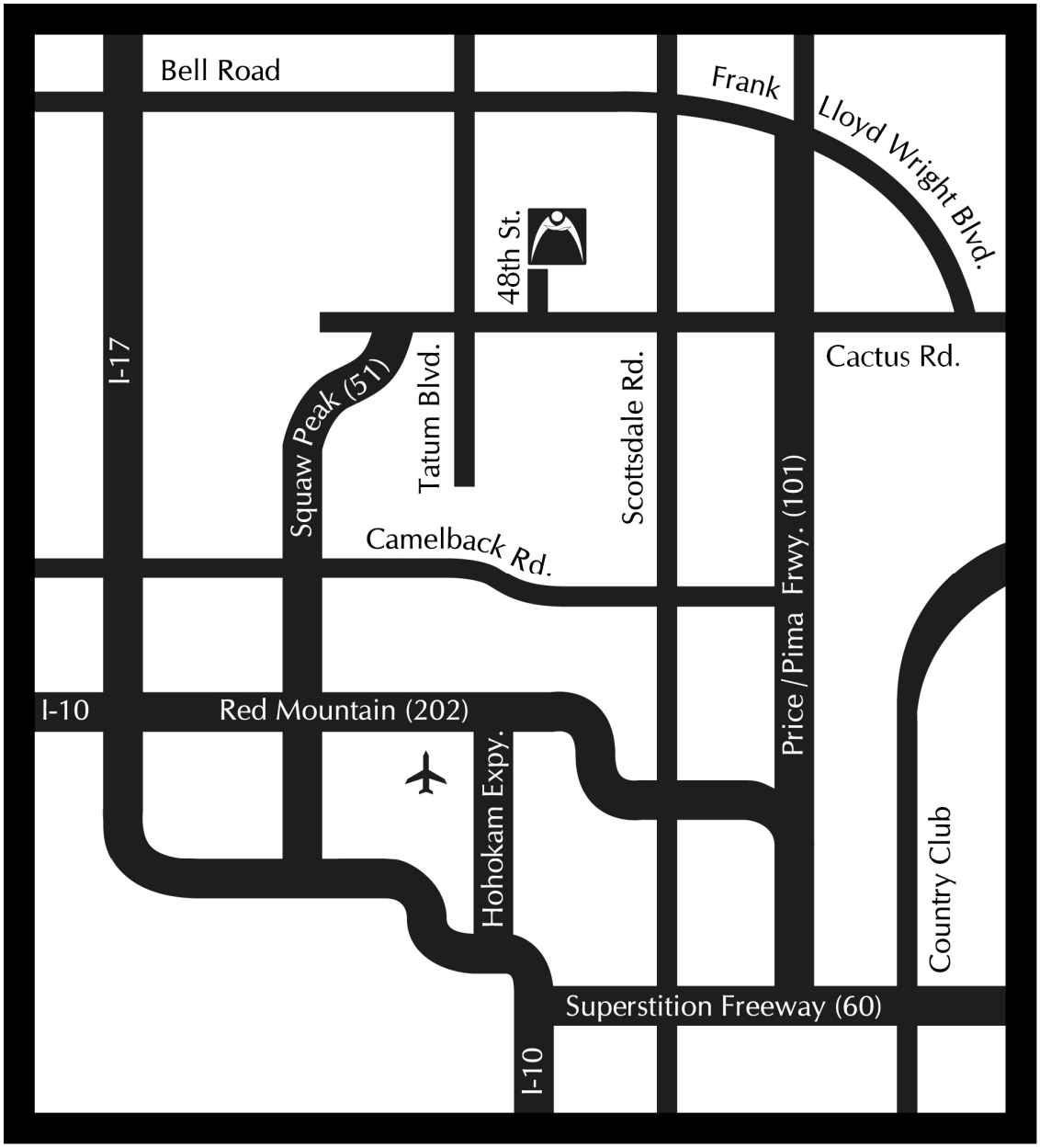
Our goal is to provide our patients with the best possible service. We have listed important items below that will assist us in providing that care. ***Please keep on file for future reference!***

- 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

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.

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.

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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)

melmed center

TM

REGISTRATION FORM

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

Patient information

Legal Name _____**Date of Birth**_____ **M/F**____
Child lives with: Mother □ Father □ Court Appointed Guardian: _____

Mother / Court Appointed Guardian Information ***(Paperwork must be provided for legal Guardians)***

Name_____**Date of Birth**_____
Address_____ **City** _____ **State** _____ **Zip** _____
Primary Phone #_____ **Secondary Phone** _____
E-MAIL: _____ ***would you like to receive updates via E-mail?*** **Yes / No**
If parents are divorced or separated, Mother has a right to request records and coordinate care? Circle Yes/ No
If no please explain: _____

Father / Court Appointed Guardian Information ***(Paperwork must be provided for legal Guardians)***

Name_____**Date of Birth**_____
Address_____ **City** _____ **State** _____ **Zip** _____
Primary Phone #_____ **Secondary Phone** _____
E-MAIL: _____ ***would you like to receive updates via E-mail?*** **Yes / No**
If parents are divorced or separated, Father has a right to request records and coordinate care? Circle Yes/ No
If no please explain: _____

I authorize Melmed Center to contact me by telephone with medical information pertaining to my child's 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 Care Givers ***(Other than biological parents/guardians)***
The following people are authorized to discuss personal health information with the Melmed Center. They are also able to coordinate care, schedule and attend appointments and may be contacted in case of an emergency.
(Only parents and legal guardians can request and transfer records)

Name _____ **Relationship** _____**Phone Number** _____

Name _____ **Relationship** _____**Phone Number** _____

PLEASE NOTE IF DIVORCED: LEGAL CUSTODY DOCUMENTS MUST BE PROVIDED

DIVORCED/SEPARATED FAMILIES
We strive to, but cannot always act as a mediator between parents under contentious circumstances. We also strive to avoid being "side-barred" by parents, lawyers or other professionals; and we hope that is respected. Both parents are always welcome, explicitly and implicitly, at all visits; indeed that is preferred. Parents are responsible for ensuring that coordination of each of their own schedules allows for both to be present. This of course requires a degree of cooperation, that if absent, will preclude the most optimal evaluation. If communication challenges exist which preclude that, it is unfortunate, especially for the child. Melmed Center will work with both parents. Therefore, it is required that you complete both parents information above unless the court dictates otherwise. Furthermore, payment must be arranged by the time of the visit. We accept payment in advance, but require it from the accompanying adult at the time of the appointment.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____
Signature of Parent/Legal Guardian

Please turn the page over and complete the other side →

melmed center

TM

REGISTRATION FORM

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

*****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.

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: Insurance cannot be billed without the patient present. Upon request you may schedule a parent consultation with your child's provider for a private pay fee.

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

melmed center

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, my child, or my family. 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, my child, or my family 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 my child. 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 Parent/ Legal Court Appointed Guardian

NUTRITION INTAKE QUESTIONNAIRE

Name _____ Age_____ Ht_____ Wt_____

Address _____

City _____ State _____ Zip Code _____ Country _____

Phone # _____ Email _____

TYPICAL BREAKFAST:

_____

TYPICAL LUNCH:

_____

TYPICAL DINNER:

_____

TYPICAL IN-BETWEEN MEAL FOODS:

_____

FATS AND OILS EATEN DAILY:

_____

SUGAR AND WHITE FLOUR EATEN DAILY:

_____

FRUITS AND VEGETABLES EATEN DAILY:

_____

LEGUMES (BEANS, LENTILS) EATEN DAILY:

_____

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WHOLE GRAINS EATEN DAILY (GERM AND BRAN):

_____

NUTS AND SEEDS CONSUMED DAILY:

_____

SEAFOOD, MEAT, POULTRY, EGGS, AND DAIRY EATEN DAILY:

_____

BINGE AND COMFORT FOODS:

_____

SUSPECTED REACTIVE FOODS:

_____

NUMBER AND USUAL TIME OF DAILY MEALS/SNACKS EATEN:

_____

RESTAURANTS AND GROCERY STORES FREQUENTED:

_____

HEALTH CONCERNS

Check any known or suspected allergies, intolerances, or sensitivities to the following:

☐ Food additives	☐ Dairy products	☐ Peanuts/ Nuts/ Seeds	☐ Soy	☐ Sugar
☐ Chocolate	☐ Corn products	☐ Wheat products	☐ Eggs	☐ Oranges/ O.J.
☐ Shellfish/Fish	☐ Yeast	☐ Dust / Mites	☐ Mildew / Mold	☐ Chlorine / Pools
☐ Lawn/Garden	☐ Pollen /Hay fever	☐ Perfumes/ Cologne	☐ Other _____	

OTHER ITEMS TO CONSIDER: (TO BE DISCUSSED IN DETAIL)

_____

List all current supplements (vitamins, minerals, herbs, fatty/amino acids, greens, etc.)

	BRAND NAME	DOSE	QUANTITY PER DAY
1.			
2.			
3.			
4.			
5.			

List all current prescription and non-prescription medications and the reason for use:

MEDICATION NAME	DOSE	CONDITION BEING TREATED
1.		
2.		
3.		
4.		
5.		

Recurrent conditions - eyes, nose, throat, lungs, digestive or urinary tract, skin, weight, insomnia, etc.:

_____

_____

_____

_____

CHECK ANY OF THE FOLLOWING, POSSIBLY RELATED TO MEAL/SNACK TIMING AND COMPOSITION:

☐ Anxiety, fear	☐ Anger, irritability, aggressiveness	☐ Mood swings	☐ Headaches/Body aches
☐ Unsocial	☐ Isolative	☐ Oppositional/Defiant	☐ Injury to self or others
☐ Depression	☐ Poor concentration	☐ ADHD	☐ Listless
☐ Poor memory	☐ Indecisive	☐ Lack of impulse control	☐ Mental fog
☐ Hyper-talkative	☐ Unable to complete projects	☐ Sleep disturbances	☐ Picky eating

OTHER ITEMS TO CONSIDER: (TO BE DISCUSSED IN DETAIL)

_____

_____

_____

EXERCISE:

_____

_____

_____

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