Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Structured Developmental History Form

The information you provide will help staff determine the care your child needs as well as any further assessments. A patient's individual background, cultural and family surroundings are important factors in her or his response to illness and treatment. Your thoroughness is critical to your child's evaluation.

Please use back of paper if you need more space for responses

Demographic Information:

Patient's Name:_____ Date of Birth: ____/____/____

Caregiver Name(s):_____

☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Foster Parent ☐ Other_____

Please note dates and circumstances related to any change in custody of this child: _____

_____

Home Address: _____ City:_____ Zip:_____

Home Phone: _____ Work Phone:_____

Cell Phone:_____

E-mail Address: _____

Child's Race/Ethnicity: _____

Child's home language: _____

Please list all persons currently residing with the patient:

Name	Age	Relationship to patient

___

Please list any family members who do not live with the patient but with whom the patient has a relationship:

Name	Age	Relationship to patient

___

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General Information:

What are the presenting concerns that brought you in for an evaluation? (Please describe the major concerns and / or goals you have in seeking help for your child. List your concerns in order of their importance to you.)

_____

_____

_____

_____

At what age were you first concerned about your child's development: _____

Brifly describe earliest signs of concern: _____

_____

Medical Background:

Pregnancy and Birth History:

Were there any complications during pregnancy with your child? ☐ YES ☐ NO

Please circle all that apply: Alcohol use Cigarette use Substance use

Hypertension Preeclampsia Diabetes

Preterm labor Preterm delivery Other: _____

Were there any complications of the birth/delivery of this child? ☐ YES ☐ NO

Please circle all that apply: Jaundice Hypoglycemia Fetal distress Failure to thrive

Feeding difficulties Genetic condition: _____

Other: _____

Gestational age at time of delivery:_____

What type of delivery (please circle)? Vaginal Cesarean Section- elective or emergency

Birth Weight: _____ Length:

_____

Was your child in the NICU? ☐ YES ☐ NO

If so, how long? _____

Please describe any complications that occurred during NICU hospitalization:

_____

_____

_____

Were there any additional complications during your child's first year of life? ☐ YES ☐ NO

If so, please describe: _____

Health History:

It is very important to have as complete of a medical history for your child as possible. Please fill out the grid below making sure to include an explanation for any question answered "yes". In your explanation please include your child's age at which the event occured, any diagnoses made and any treatments which occurred.

YES	NO	DESCRIPTION	EXPLANATION
		Frequent colds/respiratory illness	
		Frequent strep throat/sore throat	
		Frequent ear infections (tubes?)	
		Birth defects/genetic disorder	
		Lung condition/respiratory disorder	
		Allergies or asthma	
		Heart condition	
		Anemia/blood disorder	
		Kidney/renal disorder	
		Urinary problems/infections	
		Hormonal problems	
		Muscle disorder/problems	

		Joint/bone problems (x-rays, bone scans)	
		Fractured bones	
		Skin disorder/skin problems (eczema)	
		Visual disorder/vision problems	
		Eye infections	
		Neurological disorder	
		Seizures or convulsions (include any EEG's)	
		Stomach disorder/pain	
		Vomiting/digestion problems	
		Failure to gain weight/feeding problems	
		Constipation/diarrhea problems	
		Dehydration episodes	
		Hearing loss/ear disorder	
		Significant accidents	
		Head injuries/concussions	
		Ingestion of toxins, poisons, foreign objects	
		MRI/CAT scan	
		Chronic medications (for what? when?)	
		Major childhood illness (pox, coup, measles, mumps, meningitis, etc.)	

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Hospitalizations/Surgeries including approximate dates:

_____

_____

Has your child had any difficulties with feeding (i.e., sucking, swallowing, drooling, chewing, choking)?

☐ YES ☐ NO

If so, please describe_____

_____

Has your child ever been identified as: "Failure to Thrive" or had significant unexplained weight loss or gain.

☐ YES ☐ NO

Does your child have intolerances or dislikes of major food groups such as grains, fruits, starches, milk, protein, etc?

☐ YES ☐ NO

If so, please describe_____

_____

Is your child ALLERGIC to any foods or medications? ☐ YES ☐ NO

If so, please identify allergy and exposure response:_____

_____

Date of most recent hearing and vision exams/screen:

Vision_____ ☐ Pass ☐ Fail

Hearing:_____ ☐ Pass ☐ Fail

Does your child use any special equipment for daily activities, such as:

Glasses _____ Hearing Aid _____ Splints _____ Wheelchair _____ Other:_____

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List your child's previous medical, psychological and/or mental health diagnoses:

Diagnosis	Date	Professional's Name & Title	Professional's Location

List ALL medications your child is currently taking. Also, please include previous medications taken for behavior/emotion regulation and reason for discontinuing:

Medication	Start Date	End Date	Dose	Reason Prescribed	Reason Discontinued

Is there a family history of learning problems, psychological problems or mental health diagnosis in your family?

☐ YES ☐ NO

If so, please describe: _____

_____

Who is your child's Pediatrician or Family Doctor?

_____

Address: _____

Phone number:_____

Has the patient's physician or teacher identified any concerns (please circle)?

☐ YES ☐ NO

If so, please provide a brief description:

_____

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_____

Social/Emotional/Behavioral:

Regarding to your child's personality, what do you like most about your child?_____

_____

What is most challenging about raising your child?

_____

_____

Do you have any concerns about your child's social interactions with peers (same aged peers)?

☐ YES ☐ NO

If so, please provide a brief description:

_____

_____

Do you have any concerns about your child's behavior (please circle)?

☐ YES ☐ NO

If so, which of the following apply:

Hyperactive Inattentive Aggressive Defiant Disruptive Unmotivated Low Motivation

Please provide details: _____

_____

Do you have any concerns about your child's emotional functioning?

☐ YES ☐ NO

If yes, which of the following apply:

Sad/Withdrawn Manic/Euphoric Angry Anxious/Nervous Unstable Inflexible

Please provide details: _____

_____

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Has your child experienced any recent stressful events or past events that are still troubling for your child?

☐ YES ☐ NO

Please provide details (noting any history of abuse or trauma): _____

_____

_____

Who manages discipline of your child at home? _____

What strategies are used for discipline are used and how effective have they been? _____

_____

_____

What are your child's interests and hobbies?

_____

_____

Has your child had problems with any of the following beyond expected for child's age?

YES	NO	DESCRIPTION	EXPLANATION
		Sleeping problems	
		Bed wetting	
		Temper tantrums	
		Head banging	
		Breath holding or other self injury	
		Aggression	
		Nervous habits (nail biting etc.)	
		Masturbation	
		Fire play or destruction of property	

		Cruelty to animals	
		Major mood swings	
		Under or over reactive to sounds	
		Under or over reactive to clothing	
		Under or over reactive to taste	
		Under or over reactive to smell	
		Unusual or extreme fears?	
		Unusual body movements	
		Over reactive to change in routine	

Educational:

Is your child in daycare or school? ☐ YES ☐ NO

If so, where? _____What grade? _____

How many total schools has your child attended? _____ Locations? _____

Has your child ever repeated a grade? ☐ YES ☐ NO

If so, which grades? _____

Has your child ever been evaluated for special education or for a gifted program? ☐ YES ☐ NO

If so, please describe:_____

Does your child currently have an IEP or 504 Plan in place at school? ☐ YES ☐ NO

If so, please provide any information known:

Service Date Began Child's qualifying disability category

_____

_____

How would you rate your child's overall current intelligence compared to other children?_____

Do you have any concerns about your child's ability to learn or perform on school work? ☐ YES ☐ NO

If so, please describe: _____

Have you noticed any recent changes in your child's academic performance? ☐ YES ☐ NO

If so, please describe: _____

_____

Previous evaluations/services:

Who (include title) Where Dates of service (from-to)

Occupational Therapist: _____

Physical Therapist: _____

Speech Therapist: _____

Psychologist: _____

Counselor: _____

Other: _____

Developmental History:

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. **If you can not recall/find a specific age,** please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column.

Milestone	Age	Early	On Time	Not yet achieved	Good/Fair	Poor
Smiled						

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Said first words/named single objects						
Combined words (ie. me go, dad shoe)						
Use simple questions (ie. where's mom?)						
Followed simple 1-step directions						
Said 2-3 phrases						
Knew colors						
Counted to 5						
Knew alphabet						
Held head up						
Rolled over						
Sat unsupported						
Crawled on hands and knees						
Stood alone						
Walked by self						
Threw objects actively						
Ran by self						
Pedaled a tricycle						
Pedaled bicycle independently						
Caught a thrown object						
Fed self (finger feed/eats with spoon or fork)						
Drank from (bottle/spouted or special cup/regular cup)						
Brushed teeth (tolerates from parent independent)						
Dressed self						
Manipulated buttons, zippers, shoelaces						

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Bladder trained - days						
Bladder trained - nights						
Bowel trained						
Slept through the night						
Reached for an object actively						
Transferred object between hands						
Clapped hands						
Picked up Cheerios or other similar object						
Cut paper with scissors						
Scribbled with crayon						
Showed a hand preference (circle)	LEFT RIGHT					

Please list any other concerns or information we should know: _____

_____

_____

_____

What would you like to happen as a result of your child's evaluation? _____

_____ _____

Signature of Parent or Guardian Date

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Consent for Mental Health Evaluation and/or Treatment

I consent to the evaluation and/or treatment of _____ at Cornerstone Behavioral Health and Pediatric Therapies and authorize the qualified personnel thereof to perform such diagnostic procedures and administer such care and treatments as may be directed by the clinic policy or ordered and/or prescribed by the clinical staff person who is responsible for my child's care. The information herein is in addition to the information contained in the Cornerstone Notice of Privacy Practices.

I acknowledge that I have been fully informed of the evaluation procedures; care and/or treatment of my child, and any risks associated with it have been addressed to my satisfaction. I understand that I may be asked to participate in my child's therapy/ evaluation. I understand that the professionals and staff of Cornerstone Behavioral Health and Pediatric Therapies are required by Oklahoma law to report reasonable suspicions of child maltreatment. I understand that if I or my child is in danger of hurting ourselves or others, this information may be reported in order to obtain appropriate protection. I understand that professionals and staff of Cornerstone will keep records and information regarding my child's treatment confidential, except as authorized by me, as required by law, or as needed to protect persons from harm and to respond to reasonable suspicions that harm has occurred. I understand that Cornerstone professionals and staff may share information among themselves for the purposes of coordinating care, professional consultation and for other purposes necessary to carry out regular clinic operations. I understand that the information shared will be the minimum necessary to carry out these activities. I give permission for the person who brings my child for an evaluation and/or treatment to provide and to receive information concerning him/her.

I understand and agree that Cornerstone does not perform custody evaluations for children or forensic evaluations (to examine and evaluate a patient in anticipation of prosecution or litigation. I agree not to use Cornerstone's evaluation or treatment information to gain advantage in any legal proceedings related to a custodial arrangement. Additionally, I agree that in any such proceedings, I will not ask Cornerstone staff to testify in court, whether in person, or by affidavit. I agree to instruct attorneys not to subpoena Cornerstone staff or to refer in any court filing to anything Cornerstone staff have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If Cornerstone professionals are required to testify, Cornerstone professionals are ethically bound not to give their opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, Cornerstone professionals will provide information as needed (if appropriate releases are signed or a court order is provided), but Cornerstone professionals will not make any recommendation about the final decision.

Furthermore, if Cornerstone professionals are required to appear as a witness, the party responsible for Cornerstone professional's participation agrees to reimburse Cornerstone Behavioral Health & Pediatric Therapies at the rate of $750 per hour for time spent traveling, preparing reports, testifying, being in attendance and any other case-related costs.

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I understand and agree that the professionals and staff of Cornerstone, when services are billed to a 3rd party insurance provider, will contact and provide information to my insurance carrier in order to obtain payment for evaluation and/or treatment services, and to document the child's evaluation results, treatment plan (if any), and diagnosis (as required by applicable contracts). I understand that payment or co-payment, if applicable, is due at the time of service, unless other arrangements have been made in advance.

The information in this consent has been discussed with me. I have been given the opportunity to ask questions I have regarding this consent. I am legally authorized to consent to the services provided by Cornerstone for the above-named child patient.

_____ _____

Patient Name Patient DOB

_____ _____

Signature of Parent or Guardian Date of Consent

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Patient Attendance Policy

Cancelation Fee not Applicable to those with SoonerCare Insurance. In order for us to ensure the best possible results from therapy, you must actively participate in the program developed for you by attending all scheduled sessions. Please be respectful to your therapist and to other patients who are waiting to be scheduled by adhering to the following:

Sick Policy: If your child has had a fever (99 degrees or above), nausea, vomiting, or diarrhea in the past 24 hours, do not bring them to therapy. Call and let the office know. In order to resume therapy, your child must be fever and symptom free for **24 hours.**

Appointment Cancellation Policy: Call at least 24 hours in advance to cancel or reschedule any appointments. Cancellations under 24 hours are acceptable only due to illness, death in the family, or other significant family emergencies. Frequent cancellations (25% or more of total visits) will result in a **$25.00 fee** for future missed visits. We try to offer appointment times that are most convenient for your busy schedule. If you need to reschedule your appointment with short notice, please understand that you may need to see another therapist, accept a less than optimal appointment time, or wait until the next scheduled opening becomes available.

Appointment No Show Policy: Our therapists have set aside a specific time to provide your therapy. When you do not call to cancel or do not show for your appointment, this is time the therapist could be providing therapy to someone else. We understand emergencies do arise requiring schedule changes, however, we do expect a call. After three missed appointments with no notification, you will lose your scheduled appointment time. You will receive one phone call notifying you and then it will be up to you to reschedule. Once rescheduled, any future missed appointments without a 24-hour advanced notification will result in being charged the **full therapy amount.** This balance on your account will not be covered by insurance and will need to be paid before scheduling any additional appointments.

All cancellations or no shows will be reported to your referring physician and insurance company. We are not responsible for any resultant adverse effects.

**Please be informed that if your insurance requires a prior-authorization for therapy and you only attend a portion of your sessions, your insurance company will likely reduce number of visits in future authorizations or completely deny future requests.*

Acknowledgment I have read the attendance policy and acknowledge my understanding as well as agree to the terms.

_____

Patient Name

_____ _____

Signature of Parent or Guardian Date

Cornerstone Behavioral Health and Pediatric Therapies, Inc.

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY.

If you have any questions about this notice please contact Carolyn Donaghey at Cornerstone Behavioral Health and Pediatric Therapies at (405) 455-6868 or by email at office@cornerstoneok.org

This Notice of Privacy Practices describes how Cornerstone Behavioral Health and Pediatric Therapies may use and disclose your protected health information to carry out treatment, payment or health care operations as well as other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that relates to your past, present or future physical, mental health and related health care services.

Cornerstone Behavioral Health and Pediatric Therapies is required to abide by the terms of this Notice of Privacy Practices. Cornerstone Behavioral Health and Pediatric Therapies may change the terms of this notice at any time. The new notice will be effective for all protected health information maintained at that time. You may request a revised version of Privacy Practices by accessing our website or calling the office and requesting a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION:

Treatment: Information about you may be used by the personnel (including students in the field of speech-language pathology who are completing extern placements) associated with Cornerstone Behavioral Health and Pediatric Therapies for diagnosis, treatment planning and treatment. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client, the client's legal guardian or personal representative. It is the policy of Cornerstone Behavioral Health and Pediatric Therapies to release private health information to clients or the parents/guardians of clients who are minors. Should Cornerstone Behavioral Health and Pediatric Therapies need to send information to another professional, a signed Release of Information form is required.

Payment: Cornerstone Behavioral Health and Pediatric Therapies bills directly to your insurance company. You will be given a Notification of Benefits and Financial Responsibility form. You will be responsible for all services rendered which are not covered by your insurance as well as pay any co-payments and/or co-insurance amounts required.

Cornerstone Behavioral Health and Pediatric Therapies will communicate with you only in forms of communication provided on the Contact Information form you completed prior to starting therapy. It is the client's responsibility to update contact information with Cornerstone Behavioral Health and Pediatric Therapies.

OTHER DISCLOSURES: Cornerstone Behavioral Health and Pediatric Therapies may use or disclose your protected health information in certain situations without your authorization or providing you the opportunity to agree or object. Some of these situations include:

Required By Law: We may use or disclose your protected health information to the extent which the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

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Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority which is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law including audits, investigations and inspections. Oversight agencies seeking this information include government agencies which oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, reporting adverse events, product defects or problems, biologic product deviations, tracking products, enabling product recalls, making repairs/replacements or conducting post marketing surveillance as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification

and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

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YOUR RIGHTS:

You have the right to inspect and copy your protected health information. Meaning you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. Copies can be obtained for $.25 a page from our office.

Under federal law, however, you may not inspect or copy records related to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files and you may request this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement which will be placed in your file.

COMPLAINTS: If you believe your rights have been violated by Cornerstone Behavioral Health and Pediatric Therapies please bring the problem our attention first, your concerns will be addressed in a timely manner. If you are not satisfied with the manner in which the Clinical Director, Dr. Gotcher, PhD (ngotcher@cornerstoneok.org or 405-455-6868) handles a complaint, you may submit a formal complaint to:

Attn: Director Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201

This notice was published and becomes effective on signed date below. It will remain in effect for two years from this date.

_____ _____

Legal Guardian Signature Date

_____ _____

Cornerstone Representative Signature Date

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Financial Responsibility Statement

Patient Information:

Patient's full name: _____

Patient's DOB: ____/____/_____

Patient's sex: M_____ F_____

Patient's relationship to subscriber: Self___ Child_____ Other_____

Subscriber Information:

Name of subscriber: _____

Subscriber DOB: ____/____/_____

Insurance Company: _____

Member ID:_____

Group Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Cornerstone Behavioral Health & Pediatrics Therapy, and authorize Cornerstone Behavioral Health & Pediatric Therapy to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

By signing this form I am stating that I understand and agree to the following:

Fees for services were reviewed with me and agreed upon prior to the commencement of services. Payment is due at the time services are rendered unless other arrangements have been made.

All returned checks will result in a **$25.00 return fee**. Failure to meet financial obligations will result in termination of services.

I, _____, (print name) assume all financial responsibility for charges related to all services provided by Cornerstone BH&PT for _____ (print child's name).

_____ _____

Signature of Parent or Guardian Date

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Authorization for Release of Information

Patient Name: _____ Date of Birth: ____/____/____

I authorize Cornerstone to release information TO:

1. Name of Provider or Facility:_____

   Address:_____

   Phone number:_____

   Fax number:_____

   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

2. Name of Provider or Facility:_____

   Address:_____

   Phone number:_____

   Fax number:_____

   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

I authorize Cornerstone to obtain information FROM:

1. Name of Provider or Facility:_____

   Address:_____

   Phone number:_____

   Fax number:_____

   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

_____ _____

Signature of Parent or Guardian Date

_____ _____

Cornerstone Representative Date