Pathways
Developmental Pediatrics
Personalized care for individual minds

Welcome to Pathways Developmental Pediatrics!

I am honored to continue in the care of your child, and look forward to seeing you at this new practice location.

Despite seeing your child regularly, it is required to have certain forms updated and completed because of the change in practice location. I apologize for any inconvenience this may cause.

To prepare for your first visit, please use this checklist as a guide. I look forward to seeing you again!

Transfer of care to Pathways Developmental Pediatrics Checklist

- Please ***bring*** the following completed forms to your visit.
- Please allow for a little extra time to arrive at clinic to ensure a complete visit.
- Unfortunately, this practice is not set up to take Medicaid or Tricare insurances at this time.

❏ Completed Registration Form
❏ Signed Financial and Cancellation Policy Form
❏ Signed Credit Card Authorization Form
❏ Completed Parent Transfer Questionnaire
❏ Any updated IEPs, therapy evaluations, behavioral reports.
❏ A copy of our most recent visit note (*only if available*)
❏ ***Read*** the Notice of Privacy Practices listed on our website.

If you have any questions, do not hesitate to ask. I am looking forward to seeing you.

Warmly,
Evelyn Frazier, MD

232 Douglas Avenue, Suite A ○ Charlottesville, VA 22902 ○ P: 434-218-0862 ○ F: 434-473-6025
Email: evelynfraziermd@pathwayscville.com ○ Web: www.pathwayscville.com

Patient Registration

Contact Information

Child's Full Name: _____

Nickname:_____ Gender:_____ Date of Birth_____

Parent 1: _____ ☐ Mother ☐ Father ☐ Guardian
Full Name

_____
Street Address City, State Zip Phone Number

Parent 2: _____ ☐ Mother ☐ Father ☐ Guardian
Full Name

_____
Street Address City, State Zip Phone Number

Best number where you can be reached?_____

Emergency Contact Information: _____
Name

_____
Relationship Phone

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Billing Information

Primary Insurance Co: _____ Policy ID#_____

Policy Holder's Name: _____ DOB: ___/___/___

Address: _____

Secondary Insurance Co: _____ Policy ID# _____

Policy Holder's Name: _____ DOB: ___/___/___

Address: _____

Consents

Consent to Treatment of a Minor Child:

I request and authorize Pathways Developmental Pediatrics PLC, physician(s) and staff to perform necessary services for my child which are deemed advisable by the physician(s), whether or not I am present at the appointment.

_____ **(INITIAL)** I hereby authorize the following individuals to bring my child, listed above, in for treatment. These named individuals may also receive test results, and information pertinent to the treatment and care of my child.

1. _____

   Name Relationship to Patient Phone

2. _____

   Name Relationship to Patient Phone

3. _____

   Name Relationship to Patient Phone

Consent to Receive Emails and Text Messages about Appointment Reminders:

_____ (INITIAL) I consent to receive emails and text messages from Pathways Developmental Pediatrics, PLC at my cell phone number, and any number forwarded or transferred to/from that number to receive appointment reminders. I understand that this request to receive emails and text messages will apply to all future appointment reminders unless I request a change in writing.

The email that I authorize to receive messages for appointment reminders is:

_____

The cell phone number that I authorize to receive text messages for appointment reminders is:

_____

Note: Pathways Developmental Pediatrics, PLC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

_____ (INITIAL) I permit Pathways Developmental Pediatrics, PLC and the physician(s) or other health professionals involved in care to release healthcare information for purposes of treatment, payment or healthcare operations.

The above is in effect until revoked in writing by me, and receipt acknowledged by Pathways Developmental Pediatrics PLC.

_____

Parent/Guardian Signature **Name** **Date**

Acknowledgement of Notice of Privacy Practices

I was provided a copy of Pathways Developmental Pediatrics, PLC Notice of Privacy Practices which outlines how this practice may use and disclose my protected health information. I have been able to review and ask questions about the content in this notice.

I am aware that there is an additional copy of the Notice of Privacy Practices on the website of Pathways Developmental Pediatrics, PLC as well as posted in their clinic.

I acknowledge that I have received the Notice of Privacy Practices.

_____

Parent/Guardian Signature **Name** **Date**

Financial and Cancellation Policy

Patient Name: _____
Last First Date of Birth

Pathways Developmental Pediatrics is a private practice dedicated to providing personalized care for patients and families. Discussing and understanding financial and patient responsibilities is an important step in our partnership, and one that helps to ensure an aligned and sustainable medical relationship.

Patient Visits:

- I understand that Pathways Developmental Pediatrics participates in select insurance plans as listed on the website. Dr. Frazier is an out of network provider for all other insurance plans.
- I understand that I am responsible for determining if referrals are necessary for insurance reimbursement, and requesting these referrals.

For participating insurance plan holders:

- I understand that all services will be submitted to my insurance plan. Coinsurance and deductibles are my responsibility, and will be accepted at the time of service or billed to me, respectively.
- I understand that some services may not be reimbursed by my insurance plan, and I agree to pay any balances not covered by my insurance plan as outlined in the Fee Schedule.
- I acknowledge that my insurance card must be available at the time of service, or I will be charged the fee-for-service rate.

For all other health insurance policy holders:

- I agree to pay for each visit at the time of service in accordance with the published fee schedule.
- I understand that payment is due at the time of service.

Parent's Initials: _____.

Payment Policy:

- Pathways Developmental Pediatrics uses a secure, third party appointment booking program. This company stores your credit card payment information, and only the last four digits of your credit card number can be seen.
- I understand that co-pays and other out of pocket expenses will be charged at the completion of my appointment to the credit card I have put on file.

- I understand that out of pocket expenses incurred between visits will be charged to this credit card on file immediately. These expenses include, but are not limited to, no-show/late cancellation fee, telephone, refills and forms fees.
- If my participating insurance policy is subject to deductibles and/or co-insurances that cannot be collected at the time of service, I understand that Pathways Developmental Pediatrics will charge my credit card on file any outstanding balances as outlined on my Explanation of Benefits (EOB).
- It is my responsibility to understand my insurance policy and if referrals or prior authorizations are required.
- I agree to update my credit card on file when needed. I will receive a paper statement, which must be paid within 30 days, in the event my credit card on file cannot be charged.
- Payment of all statements is due upon receipt in order to remain in good standing with the practice. If charges remain unpaid, despite reasonable efforts on the part of Pathways Developmental Pediatrics to secure and notify me of necessary payments, I understand that my statements will be sent to a collection agency, and that treatment at Pathways Developmental Pediatrics cannot ethically be continued.

Parent's Initials: _____.

Cancellation Policy:

- I understand that I will be charged 50% of the visit fee if I cancel less than 48 hours prior to my appointment time, or after 11am on Fridays for Monday appointments.
- I understand that I will be charged the full visit fee if I cancel 24 hours prior to my appointment time, or no-show for my appointment without cancellation.

Parent's Initials: _____.

Late Arrival Policy:

- Dr. Frazier wants all patients to have the opportunity to be seen for his/her entire scheduled visit time. Thus, she operates under a "therapist" model; meaning, each appointment has a dedicated length of time.
- I understand that arriving late for my appointment may result in my visit being truncated to allow for others to be seen on time.
- I also understand that a shortened visit may result in an incomplete assessment, and I may need to return for further assessment.
- I also understand that if I arrive late for the visit, I may not be seen, and will still be required to pay for the appointment.

Parent's Initials: _____.

Telephone Policy:

- I understand that telephone services are typically not reimbursed by insurance.

- I understand that often, I will be asked to schedule an appointment if issues or questions arise between scheduled appointment times.
- If I require direct telephone contact with Dr. Frazier, I understand that I will be charged $35 for each 15 minute increment.

Parent's Initials: _____.

Refill Policy:

- I agree to request all refills at the time of my visit.
- I understand that if I cancel or reschedule an appointment, I may run out of my child's required medication.
- I agree to pay $35 for any refill required between appointment times due to missed or rescheduled appointments.

Parent's Initials: _____.

Forms/Paperwork Policy:

- Any letters, forms, or other paperwork that require completion by Dr. Frazier, outside of schedule appointment times, will be charged $15 per page, up to $50.
- Records are provided at appointment times. There is a $15 fee for records requested outside of appointment times.

Parent's Initials: _____.

Attorneys and Courts:

- In the event Dr. Frazier is required to work with your attorney, or is required to appear in court, the current hourly rate, billed by the quarter hour, will be charged, based on the most recent Attorney Fee Schedule.

Parent's Initials: _____.

Financial and Cancellation Policy Agreement

I have read and agree to the above financial and billing policies.

_____

Parent Signature **Written Name** **Date**

CREDIT CARD ON FILE AUTHORIZATION FORM

Today's Date: _____

Patient Name: _____Date of Birth: _____

At Pathways Developmental Pediatrics, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. This includes, but is not limited to, co-payments, and payments toward your deductible.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Card Information:

Card Type (Circle): Visa / MasterCard / Discover / AmEx

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV Code (Security Code):_____

Cardholder Signature: _____

I authorize and request Pathways Developmental Pediatrics to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.This authorization relates to all payments not covered by my insurance company for services provided to me by Pathways Developmental Pediatrics.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Pathways Developmental Pediatrics in writing and the account must be in good standing.

Guardian's Name (Print): _____

Signature: _____ Date: _____ / _____ / _____

Transfer of Care to Pathways Developmental Pediatrics
Parent Questionnaire

Date: _____

Child (Patient) Name: _____ Nickname: _____

Person(s) Completing This Form: _____

Relationship to Child: _____

DEVELOPMENTAL UPDATE

What are your child's current developmental diagnoses? (circle)

Autism	Speech Delay	Developmental Delay
ADHD	Learning Disorder(s)	Sleep Disorder
Anxiety	Sensory Processing Disorder	
Behavioral Difficulties	Social Pragmatic Communication Disorder	

Genetic Syndrome (please specify): _____

Other: _____

Is your child receiving any services outside of school?

___ Speech Therapy (please specify frequency and provider):

___ Occupational Therapy (please specify frequency and provider):

___ Physical Therapy (please specify frequency and provider):

___ ABA Therapy (please specify frequency and provider):

___ Non-ABA in-home behavioral therapy (please specify frequency and provider):

___ Other (please specify):

Please share any updates in your child's progress. What new developmental skills is he/she able to do since your most recent visit with Dr. Frazier?

What are your current concerns about your child? What are your goals for this visit?

MEDICAL HISTORY

Pregnancy, Labor, and Delivery

What number pregnancy was this for the birth mother? _____

Was your child conceived through any forms of assisted reproduction or egg/sperm donation?

_____

How many weeks gestation was your child when he/she was born? _____

Were there any fertility difficulties with this pregnancy? Circle: YES NO

If yes, please describe: _____

_____

Birth Weight: _____Delivery Method? Circle: VAGINAL CESAREAN SECTION

Please circle any complications which occurred during the pregnancy:

High blood pressure	Maternal stress/trauma	Non-Prescribed drug use
Alcohol use	Fetal Distress	Preterm Labor
Tobacco use	Infections	Bleeding

Please describe: _____

Please circle any issues your child experienced as a newborn:

Jaundice	Irritability	Poor weight gain
Low glucose	Arousal difficulties	Oxygen requirement

Please describe: _____

_____

Past Medical History

Please list all prior diagnoses your child has been given:

_____ _____

_____ _____

_____ _____

Please list any medications your child is ***currently*** taking:

_____ _____

_____ _____

Allergies and Drug Reactions: _____

HOME LIFE

Who lives at home with your child? (parents, siblings, grandparents, etc.)

If in foster care, please explain the circumstances leading to foster care.

If parents are not together, please describe custody arrangements and visitation frequency.

Is there anything which you feel is important for this evaluation which you do not wish to discuss in front of your child?

FAMILY HISTORY

For the purposes of understanding possible genetic risk factors, this section refers to what is known about any biologically related relatives of your child.

Age of mother at child's birth: _____Occupation: _____

Age of father at child's birth: _____Occupation: _____

Please describe any medical or developmental concerns which occur in your child's (genetically related) family members. Consider immediate family in addition to more distant relatives such as grandparents, cousins, aunts.

Diagnosis/Condition	Check if Applicable	Family Member (relationship to child)
Autism		
ADHD		
Learning Difficulties		
Intellectual Disability		
Speech Delay		
Motor Delay		

Cerebral Palsy		
Bipolar Disorder		
Depression		
Anxiety		
Schizophrenia		
Alzheimer's Disease		
Cancer		
Cardiac/Heart Disease		
Early Death		

ADDITIONAL INFORMATION

Is there anything else that you would like us to know? Please share any additional comments or concerns.