GIFTED/IQ INTAKE PACKAGE

CHILD INFORMATION

Today's date: _____ Referred by _____

Child's name: _____ Date of Birth: _____

Birthplace: _____ Age: _____ Social Security #_____-____-_____

Grade:_____ School: _____ School phone:_____

Home street address: _____

City: _____ State: _____Zip:_____

PARENT'S CONTACT INFORMATION

Parent's name_____

Cell phone: (____)_____ confidential messages can be left at this #? ☐No ☐Yes

Home phone: (____)_____ Confidential messages can be left at this #? ☐No ☐Yes

Work phone: (____)_____ Confidential messages can be left at this #? ☐No ☐Yes

Email address:_____Is this your private email address? ☐No ☐Yes

Calls and emails will be discreet, but please indicate any restrictions:_____

Are you able to reschedule and/or to confirm appointments by email? ☐No ☐Yes

Are you able to reschedule and/or to confirm appointments via text message? ☐No ☐Yes

Would you like to receive invoices and receipts by email? ☐No ☐Yes

Emergency contact:_____ Phone: _____

REASON FOR SEEKING GIFTED/IQ TESTING

Briefly state reason for seeking Gifted/IQ Testing at this time:_____

_____

_____

SOUTH BEACH OFFICE (PRIMARY): 1000 5TH STREET, SUITE 215 ▪ MIAMI BEACH, FL 33139
AVENTURA OFFICE: 17501 BISCAYNE BOULEVARD., SUITE 450 ▪ AVENTURA, FL 33160
(P)786.942.9425 (E)DR@DRNETTASHAKED.COM (F)786.369.1969
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FAMILY HISTORY

Mother/Parent 1 Name:_____ Age:_____Date of Birth:_____

Occupation: _____ Highest Degree: ☐High school ☐2 year college

☐4 year college ☐Master's ☐JD/PhD/MD Field of Study_____

Father/Parent2 Name:_____ Age:_____Date of Birth:_____

Occupation: _____Highest Degree: ☐High school ☐2 year college

☐4 year college ☐Master's ☐JD/PhD/MD Field of Study_____

Does child live with both biological parents? ☐No ☐Yes. Since when? ☐ Since birth

☐ ___ Months ☐ ___ Years ☐ Other:_____

Are parents: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Living with Someone

Briefly describe parent's current relationship with spouse/significant other_____

_____

Have custodial arrangements changed recently? ☐No ☐Yes If yes, when? _____

Does the child have siblings? ☐No ☐Yes. If Yes, please specify:

Name	Age	Sex	Living at home?
_____			☐No ☐Yes
_____			☐No ☐Yes
_____			☐No ☐Yes

Is anyone else living in the home? ☐No ☐Yes. If Yes, please specify:

Name	Age	Sex	Relation to Child
_____			
_____			

DEVELOPMENTAL HISTORY

My child is: ☐Left-handed ☐Right-handed ☐ Unknown ☐ Other:_____

What is your child's primary language? _____

What other languages does your child speak? _____

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What is the primary language spoken at home?_____

What other languages are spoken at home?_____

My child has been exposed to English: ☐ Since birth ☐ ___ Months ☐ ___ Years

My child has been speaking English: ☐ Since first talking ☐ ___ Months ☐ ___ Years

My child was born at _____ weeks, at _____ weight with: ☐ with no apparent complications

My child's delivery: ☐ c-section ☐ vaginal ☐ VBAC

As a newborn, my child was: ☐ premature (___ weeks) ☐ underweight (___ pounds) ☐ born with difficulty breathing ☐ admitted to NICU ___for observation or ___ for treatment

Any complications during pregnancy, birth, or after delivery for either Mother or Child? ☐No ☐Yes

If Yes, please describe:_____

Please provide approximate age for the following tasks:

Sitting alone_____ Crawling _____ Standing alone_____ Walking alone_____

Speaking first words_____ Speaking short sentences_____ Toilet-trained day_____

Toilet-trained night_____ Stopped bottle/breastfeeding_____ Stopped pacifier_____

MEDICAL HISTORY

Pediatrician's Name_____ Height_____ Weight_____

Allergies? ☐No ☐Yes. If Yes, please list_____

Vision test done? ☐No ☐Yes. If Yes, results were: ☐Normal ☐ Other:_____

Hearing test done? ☐No ☐Yes. If Yes, results were: ☐Normal ☐ Other:_____

Any other known sensory motor problems? ☐No ☐Yes. If Yes, please list_____

Any medical/psychiatric conditions, past or current? ☐No ☐Yes. If Yes, please list_____

_____

Is your child currently taking any medications? ☐No ☐Yes. If Yes, please complete:

Medication Name	Strength & Quantity	For how long?	For what condition?

_____

_____

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History of head injuries (loss of consciousness), seizures, hospitalizations or surgery? ☐ No ☐Yes ☐

If yes, please specify:_____

EDUCATIONAL HISTORY

Child's pre-kindergarten experience: ☐ no formal program ☐ formal preschool from age:_____

☐Other:_____

Child's pre-first experience: ☐ no formal program ☐ ½ day kindergarten from age:____ ☐ Full day

kindergarten from age:____ ☐Other:_____

Please list schools your child has attended:_____

_____

Is your child in any special classes? ☐No ☐Yes. If Yes, please describe:_____

Has your child ever repeated a grade? ☐No ☐Yes. If Yes, please describe:_____

Has your child ever skipped a grade? ☐No ☐Yes. If Yes, please describe:_____

Please rate the following:

Past school attendance: ☐Poor ☐Fair ☐Good ☐Excellent. Please describe:_____

Current school attendance: ☐Poor ☐Fair ☐Good ☐Excellent. Please describe:_____

Past conduct: ☐Poor ☐Fair ☐Good ☐Excellent. Please describe:_____

Current conduct: ☐Poor ☐Fair ☐Good ☐Excellent. Please describe:_____

Past academic performance: ☐Poor ☐Fair ☐Good ☐Excellent. Please describe:_____

Current academic performance: ☐Poor ☐Fair ☐Good ☐Excellent. Please describe:_____

In which subjects does your child perform best?_____

In which subjects does your child perform worst?_____

Is there a member of the family who has/had learning difficulties, was in a special class, repeated a grade,

or skipped a grade? ☐No ☐Yes. If Yes, please describe:_____

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SOCIAL AND EMOTIONAL HISTORY

Has your child had previous psychotherapy or was she/he seen by a psychiatrist for emotional, behavioral, or attention problems? ☐No ☐Yes. If Yes, please specify:_____

Please mark any of the following problem areas:

☐ Eating ☐ Sleeping ☐ Nightmares ☐ Thumb-sucking ☐ Nail-biting ☐ Bed-wetting

☐ Wetting in clothing ☐ Soiling in bed ☐ Soiling in clothing ☐ Getting along with peers/friends

☐ Daily activities (dressing, bathing, etc.)

What are your child's hobbies, extracurricular activities, or interests?_____

_____

How many friends does your child have? ___ # male friends with age range:_____

___ # female friends with age range:_____

OTHER

Is there anything else that Dr. Shaked should know that doesn't appear on this or other forms, but that is or might be important? _____

_____

_____

My signature/electronic signature below indicates that I have voluntarily and accurately completed the Dr. Netta Shaked, PA Intake Package. A photocopy of this agreement will be considered as valid as an original.

*Parent/Guardian Signature/Electronic Signature*_____

*Printed Name*_____ *Date* _____

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PATIENT PAYMENT RESPONSIBILITY AGREEMENT

Parent, please read below and initial:

_____To prepare your child for Gifted/IQ Testing, please make sure your child is well rested and well-fed on the day of testing. Please bring snacks and a drink for breaks. It is best to test the child at the time of day when he/she is usually most alert and energetic, so the testing session should be scheduled during such time frames.

_____If Dr. Shaked agrees to test the child in your home, and you have elected to do so, you'll be responsible for providing a quiet environment, free of interruptions, distractions, and noises. If you have elected to test your child at your home, you will not hold Dr. Shaked responsible for any interruptions, distractions, and noises which may impact your child's performance and/or outcome score(s) on the evaluation(s).

_____ You assume financial responsibility for yourself and for your child. You understand that the fee for Gifted/IQ testing is $400. This fee is payable in two parts: a deposit of $200 payable at the time of scheduling the testing session, and a second payment of $200, the balance due, payable on the completion of the testing session. This fee includes the testing session, scoring, interpretation, and a Miami-Dade Public School compliant report, along with a brief explanation of the test results to the parents.

_____ Because Dr. Shaked's time has been reserved exclusively for you and your child, you are required to provide 24 hours advance notice of cancellation. In the event that you do not provide 24 hours advance notice, your deposit will not be refunded. In the event that you do not cancel the appointment and 'no show', you will be responsible for the full testing fee. Dr. Shaked reserves the right to waive these cancellation fees, at her discretion, for emergencies or unusual circumstances.

_____ In case of a returned check or an invalid credit card, you will be charged a $30 fee. If the account is not satisfactorily paid, Dr. Shaked reserves the right to use a collection agency and legal means, and all legal fees will be included in the claim and charged to you. In most collection situations, the only information released is patient's name, nature and date of services provided, and the amount due.

_____ You authorize Dr. Shaked to maintain on file and to charge the following credit card for any and all outstanding fees that have not been paid:

Type: ☐Visa ☐Mastercard ☐AMEX Credit Card #:_____

Exp. Date:_____ Auth. Code:_____Name as it appears on card:_____

Billing Address ☐ Same as Home Address ☐ Other:_____

*Parent/Guardian Signature/Electronic Signature*_____

*Printed Name*_____ *Date* _____

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CONSENT FOR TESTING

I hereby give consent as a parent/legal guardian for my child to participate in Gifted/IQ Testing with Dr. Netta Shaked, PA. I understand that it is my sole responsibility to notify my child's other parent of these psychological services. I also understand that no promises have been made to me as to the results of evaluation, or of any other services provided by Dr. Netta Shaked, PA. I am aware that I may discontinue services at any time.

I understand that Dr. Netta Shaked is a licensed psychologist in the State of Florida, license #: PY 7699. I have the right to inquire about the credential, education, and experience of Dr. Netta Shaked, and to have my questions answered to my satisfaction.

I am aware that the procedures utilized for selecting, administering, and scoring psychological tests; interpreting and storing test results; and maintaining my privacy will be carried out in accordance with the rules and guidelines of the American Psychological Association, the State of Florida statutes, and other relevant professional organizations. All service-related documents, psychological tests, and test results will be kept in a secure place.

Historically, mental health services have been associated with absolute confidentiality between the patient and the clinician. Currently, Federal and Florida laws and regulations and professional ethics require clinicians to maintain complete confidentiality of information and communications revealed in the course of treatment. In these cases, the clinician cannot release any information about the patients and/or the patient's family without expressed and informed permission. There are some exceptional circumstances where clinicians are required or permitted to communicate information about mental health services to person outside the family. These exceptions include:

- The patient presents a clear and present danger to himself/herself and refuses to accept appropriate treatment.
- The patient communicates to the clinician an imminent threat of physical violence against a clearly identified or reasonably identifiable victims, or the clinician has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The patient introduces his/her mental condition as a defense in a legal proceeding.
- In child custody or adoption cases, the judge determines that the clinician has information bearing significantly on the client's ability to provide suitable care or custody and this information bears significantly on the welfare of the child.
- The patient initiates legal action against the clinician, and the patient information is necessary or relevant to the clinician's defense.
- The clinician has grounds to believe that a child under the age of 18, an elderly person over the age 60, or a handicapped adult has been or is at risk of being abused or neglected.
- A Judge orders a clinician to release client information.

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Consent for Testing/Page 2

I have discussed my responsibility for payment, and I assume financial responsibility for myself and my family members for all psychological services rendered, including psychological testing.

I understand that the scope of Dr. Netta Shaked, PA's services is only limited to the testing, scoring, interpretation and reporting of my child's Gifted/IQ Evaluation. By contracting to provide such Gifted/IQ testing, Dr. Netta Shaked, PA is not engaging in any psychotherapy services.

My signature/electronic signature below shows that I have read, understand, and agree with all of the statements within this Consent for Treatment. A photocopy of this agreement will be considered valid as an original.

*Parent/Guardian Signature*_____

*Printed Name*_____ *Date* _____

My signature/electronic signature below shows that I have received the attached (on next page) HIPAA Notice of Privacy Practices regarding the use and disclosure of my Protected Health Information from Dr. Netta Shaked, PA and that I consent to the use and disclosure of my Protected Health Information for the purposes of Treatment, Payment, and Health Care Operation on this date:

*Parent/Guardian Signature*_____

*Printed Name*_____ *Date* _____

INSTRUCTIONS:

So as to save time during your first appointment, please email/fax this form to Dr. Shaked at least one day before your appointment.

If you are concerned about email security, please password protect this document, after completing it.

Please use your last name as the password, followed by 123. For example, Jane Doe's password would be "Doe123"

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION AND RELEASE OF INFORMATION FORM

I_____ (*print name of parent/guardian*) understand that Dr. Netta Shaked, PA is authorized by me to disclose my child's Protected Health Information (PHI) for purposes which include diagnosis, treatment, evaluation, consultation, gathering information, and/or other psychological services. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipients of that information. I specifically authorize Dr. Netta Shaked, PA to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be PHI. I further understand that I retain the right to revoke this authorization.

Name of recipient (include phone, fax and email) with whom Dr. Shaked may exchange information:

1. _____
2. _____

Purpose of this disclosure:
☐ To facilitate treatment and/or evaluation of myself or my family, if applicable
☐ To convey test results and evaluation recommendations
☐ Other: _____

I am aware that I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, Dr. Netta Shaked, PA must receive the revocation in writing and must include: 1. Patient's name, address, and date of birth; 2. Effective date of the authorization and the recipients authorized; 3. The patient's desire in writing, to revoke this authorization; and 4. The date of revocation and the patient's signature. All revocations must be sent to Dr. Netta Shaked, PA and are not effective until received.

This authorization shall expire: ☐ Upon completion of treatment, evaluation and/or provisions of recommendations; or ☐ Date:_____

After the expiration, Dr. Netta Shaked, PA can no longer use or disclose my PHI without first obtaining a new authorization form. I fully understand and accept the terms of this authorization.

*Parent/Guardian Signature/Electronic Signature*_____

*Printed Name*_____ *Date* _____

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HIPAA NOTICE OF PRIVACY AND HEALTH INFORMATION PRACTICES

Please keep this document for your records.

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction. Dr. Netta Shaked, PA is committed to treating and using your health information responsibly. This Notice of Health Information Practices describes the personal information I collect and how I use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice is effective June 1, 2005, and applies to all Protected Health Information as defined by Federal Regulations.

Understanding your Health Record and Health Information. At every individual, couples, family, and/or group sessions; consultation; evaluation; and or other times you meet with me, a record of your visit is made. Typically, this record contains diagnoses, symptoms, treatment, and plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communicating among the many health professionals who contribute to your care
- Legal document describing the care you received,
- Means by which you or a third-party payer (i.e., insurance company) can verify that services billed were actually provided,
- Source of information for public health officials charged with improving the health of the State and the Nation, as required by law (i.e., reporting child abuse and neglect or reporting domestic violence),
- Basis for disclosing your health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, and other law enforcement purposes,
- Source for public safety. I may disclose your health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public, and
- Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights. Although your health record is the physical property of Dr. Netta Shaked, PA, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Health Information Practices upon request,
- Inspect and copy your health record, as provided for in 45 CFR 164.524,
- Amend your health record, as provided for in CFR 164.528,
- Obtain an accounting of disclosures of your health information, as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or alternative locations,
- Request a restriction on certain uses and disclosures of your information, as provided in 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.

Dr. Netta Shaked, PA's Responsibilities. Dr. Netta Shaked, PA is required to:

- Maintain the privacy of your health information,
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this Notice,
- Notify you if I am unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make new provisions effective for all protected health information I maintain. Should my practices change, I will mail a revised notice, provided those changes affect your health information, to you at the address you have supplied, and/or I will email the revised notice to you.I will not use or disclose your health information without your authorization, except as described in this Notice. I will discontinue using or disclosing your health information after I have received a written revocation of the authorization, according to the procedures included in the Authorization.

For More Information or to Report a Problem
If you have any questions or would like additional information, you may contact Dr. Netta Shaked, PA at 786.942.9425. If you believe your privacy rights have been violated, complaints should also be directed to Dr. Netta Shaked, PA. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, US Department of Health.

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